

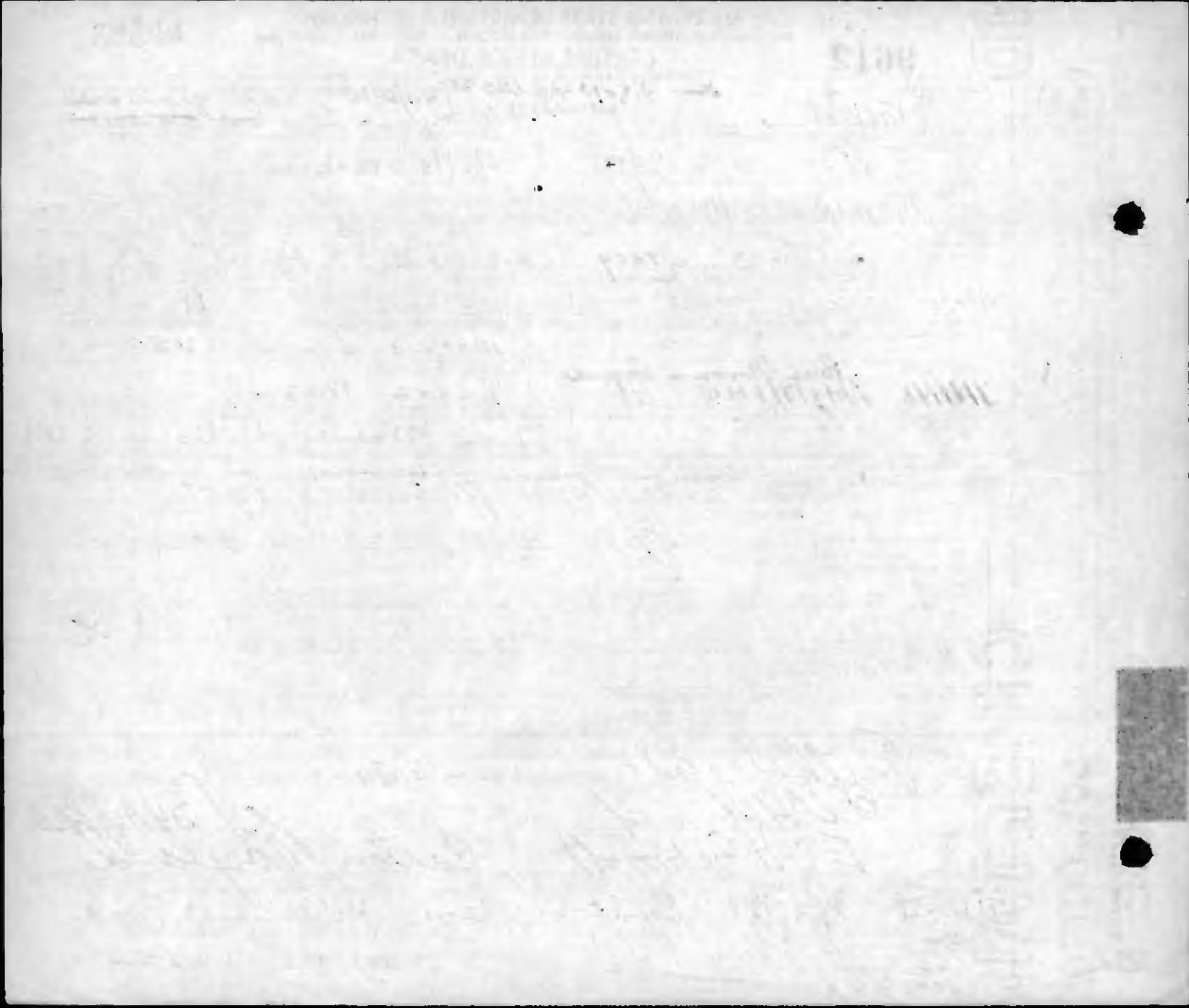
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09583

9612		CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		Items 3, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 60 et Items 3, 8, + 13 - 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 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1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1410, 1411, 1412, 1413, 14									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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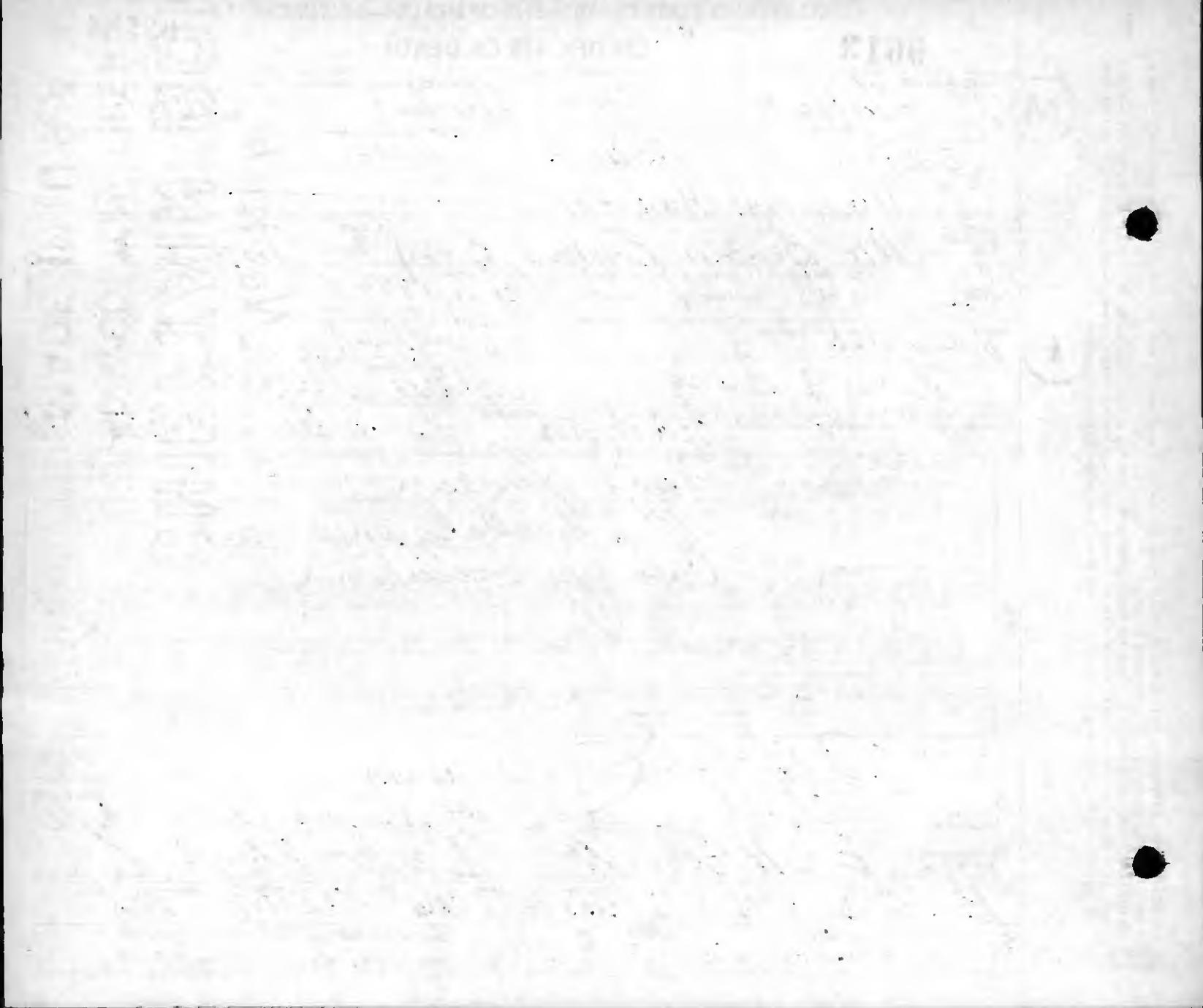
CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>25 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. Benson Bradford Biery</i>		4. DATE OF DEATH Month <i>August</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Male</i>		6. COLOR OF HAIR <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 11 1874</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mailman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>A.S.</i>			
13. FATHER'S NAME <i>Edwin J. Biery</i>		14. MOTHER'S MAIDEN NAME <i>Adeline Warner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>824-18-4562</i> INFORMANT <i>Louis Biery Easton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Myocardial aneurism</i>			
(c) DUE TO <i>Congestive heart failure</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2195 Westington St. 3rd fl</i>	
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		DATE SIGNED <i>3 Aug 60</i>	
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>			
22a. BURIAL, CREMATION, (Please Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 5, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Springside Cem.</i>		22d. LOCATION (City, town or county) (State) <i>Easton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Macree & Newnam & Son</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 8 '60</i>	
ADDRESS <i>Easton, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



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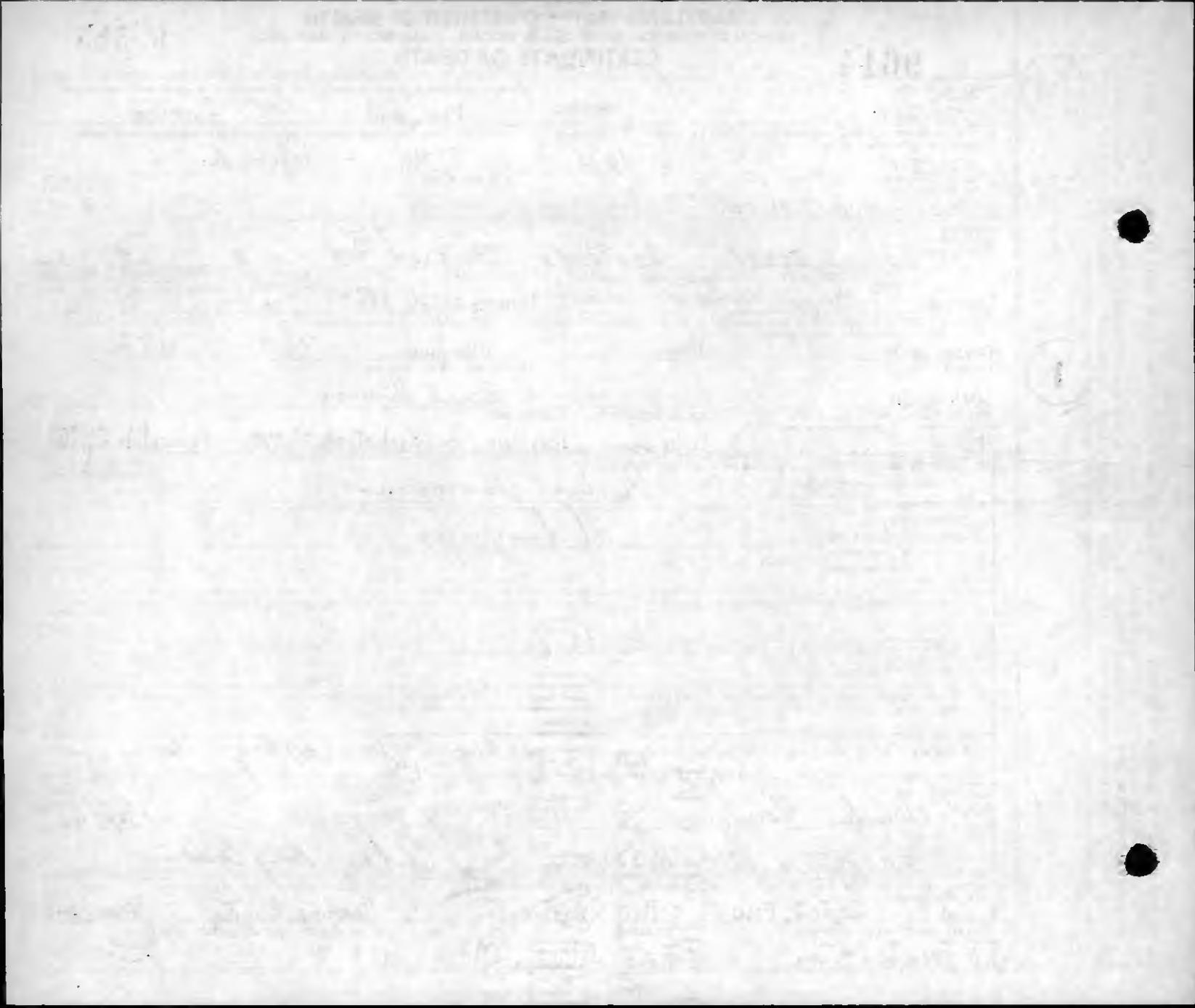
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09585

9614

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL - Federalsburg</i>		d. STREET ADDRESS <i>OSX-2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Ethel</i>	Middle <i>Gertrude</i>	Last <i>Blockson</i>	4. DATE OF DEATH Month <i>8</i>	Month <i>8</i>	Day <i>29</i>	Year <i>1960</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>November 26, 1883</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>Emma Cannon</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No No</i>		17. INFORMANT <i>Mrs. Wm. B. Ricketts</i>	Address <i>RFI - Federalsburg, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<i>Cerebral thrombosis - c</i>			INTERVAL BETWEEN ONSET AND DEATH	
		DUE TO (c)		<i>Al. hemiplegia</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>23 Aug 1960</i> to <i>25 Aug 1960</i> , that (I) (we) last saw the deceased alive on <i>26 July 1960</i> , and that death occurred at <i>4 AM</i> , from the causes and on the date stated above.								22b. DATE SIGNED <i>1 Sept 60</i>
22a. SIGNATURE <i>Thorston Harrison</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1 Sept 60</i>				
22c. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		22d. ADDRESS <i>Captain Henry Land</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 2, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Caroline County Maryland</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frampton & Son</i>		ADDRESS <i>Federalsburg, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 6 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Ollie & Thome</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

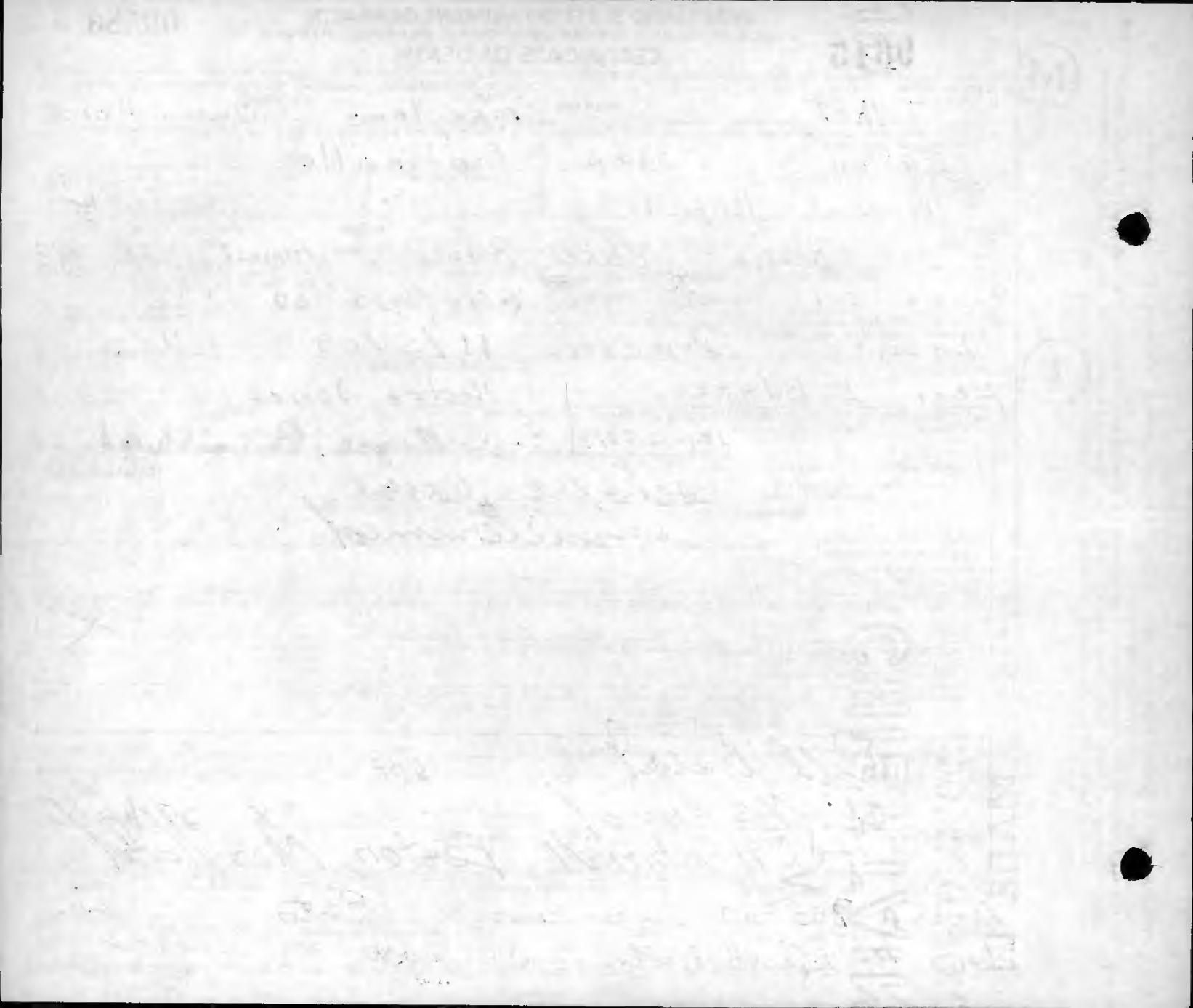
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09586

9615

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 33 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Queen Anne	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 17X-2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bessie Blake Boyce		First	Middle	Last	4. DATE OF DEATH August 28 1960	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1910	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) 11/5/09		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry E. Blake		14. MOTHER'S MAIDEN NAME Hester Jones							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 184-22-5779		17. INFORMANT Earl Boyce, Centreville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 790-1		DUE TO Cochleoxia causal							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unstated		DUE TO undetermined (c) unstated							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) EASTON		(County)	(State)
21. I certify that (I) (This Hospital) attended the deceased from _____ to _____, that (I) (we) lost saw the deceased alive on _____ and that death occurred on 19/08 , from the causes and on the date stated above.									
22a. SIGNATURE Dr. Schmidt		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 29 Aug 60	
22c. PHYSICIAN'S NAME (Type) F. C. H. Schmidt		22d. ADDRESS EASTON, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-3-60		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City, town, or county) EASTON		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Schmidt, EASTON, MD.		ADDRESS		25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE Charles S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,8,9 FilmG271 9-15-60 et

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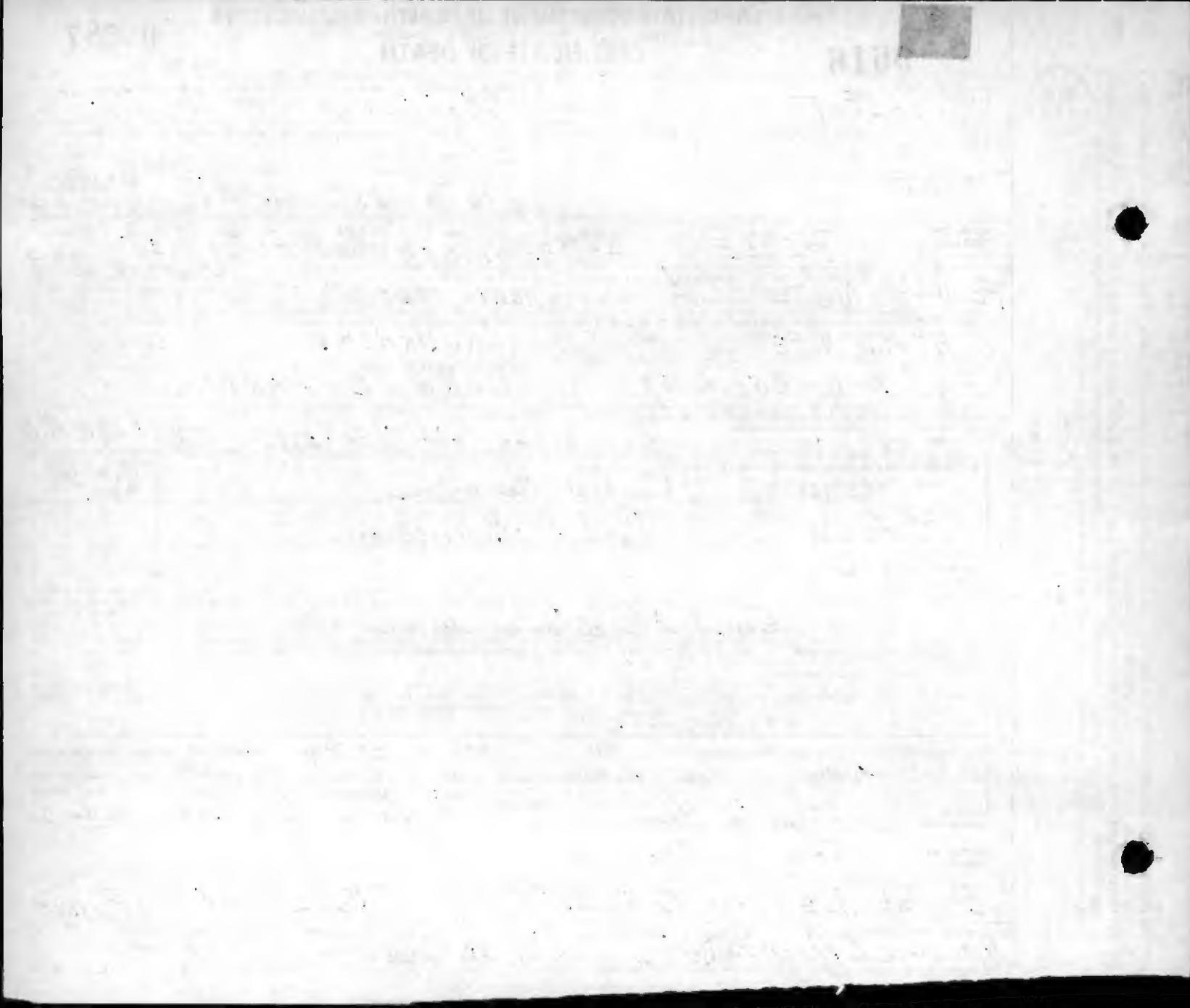
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>		e. STREET ADDRESS <u>616 GOLDSBORO ST</u>	
3. NAME OF DECEASED (Type or print) <u>BELLE</u>		First <u></u> Middle <u>A</u> Last <u>BREININGER</u>	4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1960</u>
S. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 10, 1960</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>
13. FATHER'S NAME <u>FRED - W - ANTHONY</u>		14. MOTHER'S MAIDEN NAME <u>CORA - L - PARKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u></u>	INFORMANT <u>MRS. BELL ANDREWS</u> Address <u>HORLOCK MD.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral atherosclerosis</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Essential hypertension, chronic</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or Town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>25 Aug</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>25 Aug</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Maryland</u> DATE SIGNED <u>26 Aug 60</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, BURIAL <u>FAIRVIEW CEM.</u>	22b. DATE THEREOF <u>AUG. 29, 1960</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>FAIRVIEW CEM.</u>	22d. LOCATION (City, town, or county) <u>KUTZTOWN</u> (State) <u>PENNA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neumann</u>	ADDRESS <u>Easton Md.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



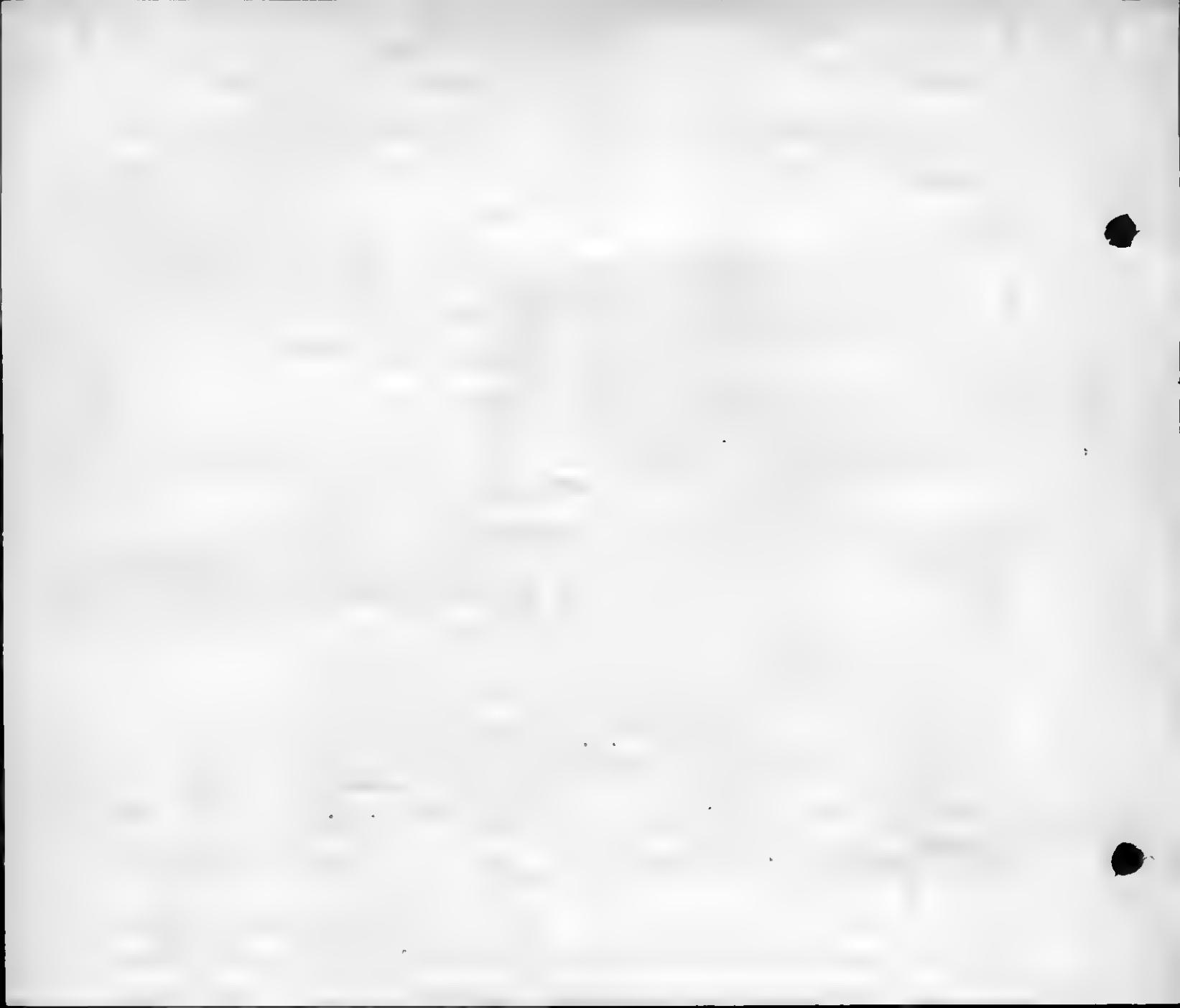
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wittman</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Wittman</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clifton</i>		First	Middle	Last	4. DATE OF DEATH Month <i>8</i> Day <i>15</i> Year <i>1960</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/19/07</i>		9. AGE (In years last birthday) <i>53 yrs</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cyster Laker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cyster</i>		11. BIRTHPLACE (State or foreign country) <i>MARYland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Brooks</i>		14. MOTHER'S MAIDEN NAME <i>MARY F. Makoney</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-65-0231</i>		17. INFORMANT <i>Mrs Dorothy Brooks Wittman, n.d.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>HIDDEN</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EMBOLUS</i> <i>463X</i> DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>PHLEBITIS OF LEG VEINS</i> DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>EASTON, Md.</i> (County) <i>Wicomico Co.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>P.M.</i> , 19 <i>60</i> , to <i>1960</i> , that I last saw the deceased alive on <i>1960</i> , and that death occurred at <i>3P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>EASTON, Md.</i> DATE SIGNED <i>8-16-60</i>	
ACTUAL SIGNATURE <i>Louis S. Welty</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>LOUIS S. WELTY</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/19/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Wicomico Cem.</i>		22d. LOCATION (City, town, or county) <i>EASTON, Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James D. Dauchill, Easton, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>John J. Thompson</i>	
VS A15(4) 15M 9/55				DATE <i>AUG 26 '60</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										09589			
9617 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Fairhope</i>					2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Maryland</i>					b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Easton</i>					c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Churchton</i>								
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <i>Memorial Hospital</i>					d. STREET ADDRESS <i>552</i>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Robert</i>	Last <i>Butler</i>	4. DATE OF DEATH Month <i>Aug</i>		Day <i>25</i>	Year <i>1960</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 26, 1883</i>		9. AGE (In years last birthday) <i>77</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm owner</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Wm. Richard Butler</i>					14. MOTHER'S MAIDEN NAME <i>Catherine Wood</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>740-07-0000</i>		17. INFORMANT <i>Mrs. Alice Fletcher Denton</i>		Address <i>Denton</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Haste</i>					DUE TO <i>inflammation</i>					INTERVAL BETWEEN ONSET AND DEATH <i>0 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>inflammation</i>					DUE TO <i>inflammation</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour <i>a.m.</i>		Month <i>Aug</i>	Day <i>28</i>	Year <i>1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Churchton</i>		20f. (City or town) <i>Denton</i>		(County) <i>Md</i>	(State) <i>Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 28</i> to <i>Aug. 29</i> , 1960, that (I) (we) last saw the deceased alive on <i>Aug. 28</i> , 1960, and that death occurred on <i>Aug. 29</i> , 1960, from the causes and on the date stated above										22b. DATE SIGNED			
22a. SIGNATURE <i>Wm. Richard Butler</i>					M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <i>Wm. Richard Butler</i>					22d. ADDRESS <i>552 Churchton</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug. 28, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>			23d. LOCATION (City, town, or county) <i>Denton</i>			(State) <i>Md</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Lloyd Mooreson Denton, Md</i>		ADDRESS			25a. REC'D BY REGISTRAR <i>Aug 29 '60</i>			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

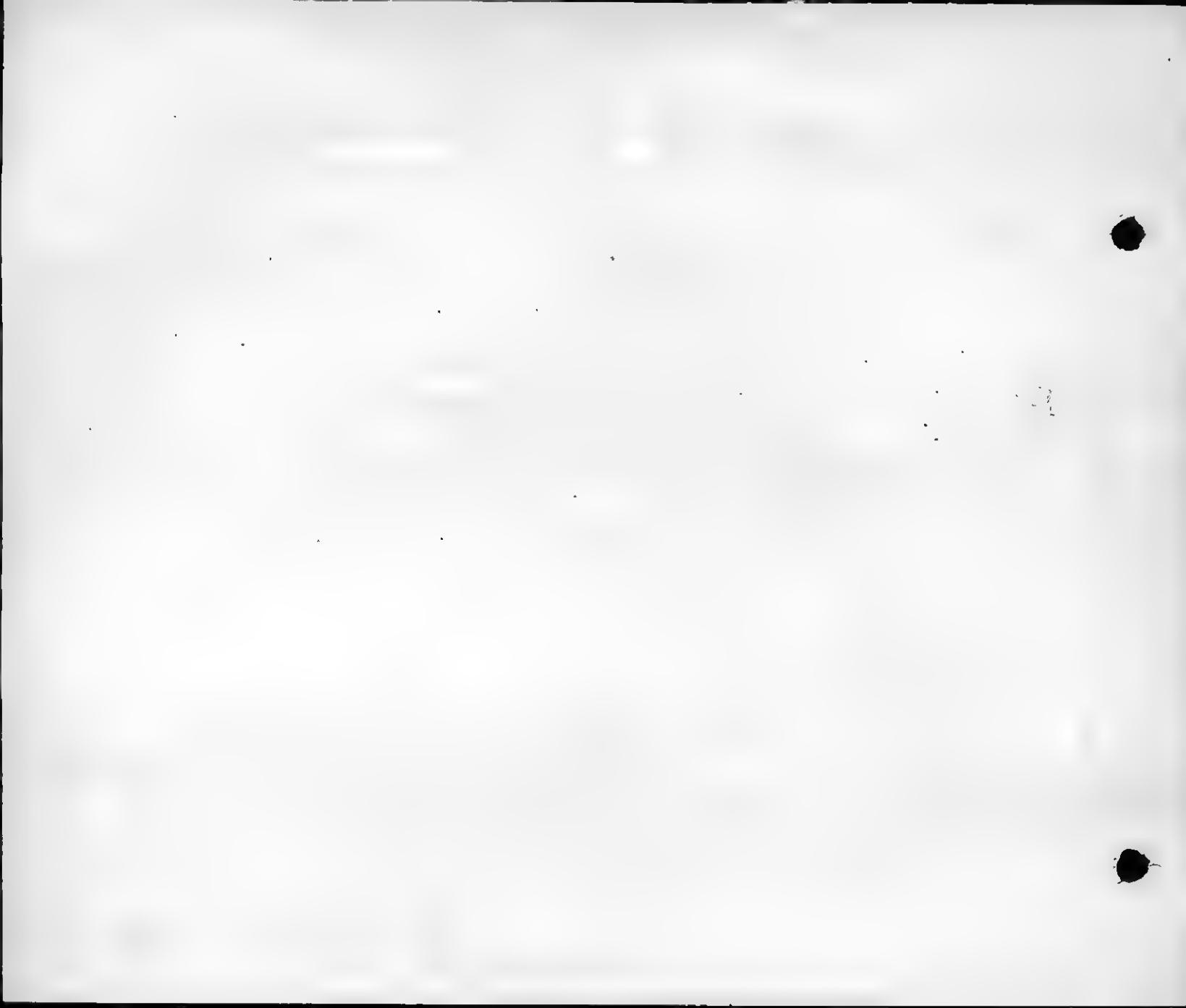
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9643

09590

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Sabot</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>George Mills</i> c. LENGTH OF STAY IN 1b <i>17 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Sabot</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>George Mills</i> d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Francis</i> Middle <i>Lytia</i> Last <i>Cawthon</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>29</i> Year <i>1960</i>						
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 1894</i>	9. AGE (in years, last birthday) <i>66</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>6</i> Days <i>25</i> Hours <i>00</i> Min <i>00</i>	11. BIRTHPLACE (State or foreign country) <i>Queens County N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		13. FATHER'S NAME <i>Jeffrey White</i>				14. MOTHER'S MAIDEN NAME <i>Mary Montague</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>555-12-3456</i>		17. INFORMANT <i>Eldon Lee Cawthon - Easton, Md.</i>		Address <i>Address</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Essential Hypertension		DAYS <i>1 yr.</i>				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Easton</i> (County) <i>St. Mary's Co.</i> (State) <i>Md.</i>				
21. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>July 19 to Aug. 19 1960</i> , that (II) (<i>we</i>) last saw the deceased alive on <i>Aug. 19 1960</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.				22b. DATE SIGNED <i>8/31/60</i>				
22c. SIGNATURE <i>Irvin G. Hoyt</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt MD</i>		22d. ADDRESS <i>Queenstown, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 1960</i>		23b. DATE THEREOF <i>Sept 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		23d. LOCATION (City, town, or county) <i>Easton</i> (State) <i>Md.</i>		
24. FUNERAL DIRECTORY SIGNATURE <i>McGill</i>		ADDRESS <i>Easton Md</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		
VR A15 (4) ISM 9/59				DATE <i>SEP 2 '60</i>				



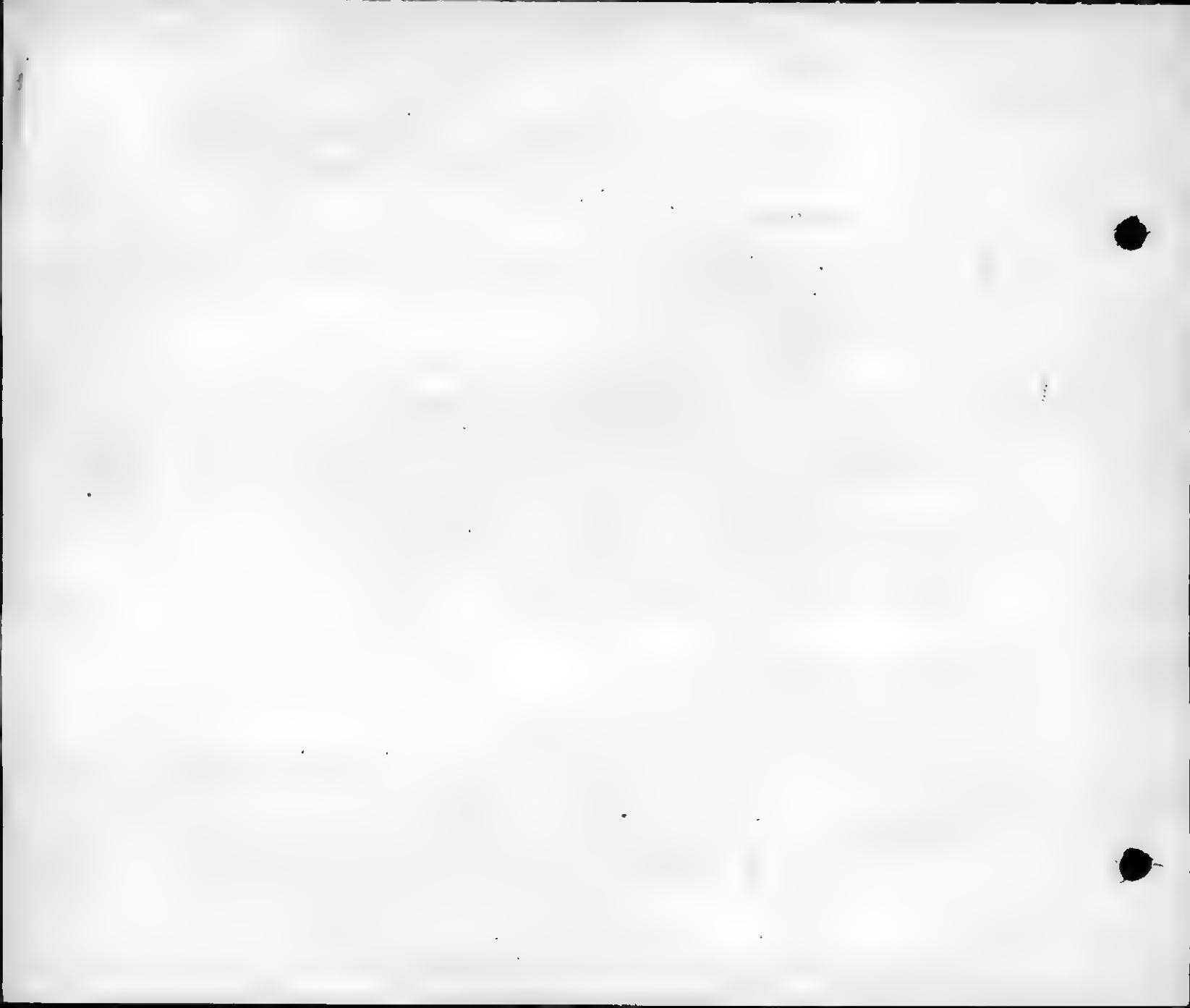
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09591

9618

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Talbot MARYLAND		Md. Hullock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN b 15 da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp. tal		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hullock	
3. NAME OF DECEASED (Type or print) Orem FRANCIS		First	Middle
		Last	4. DATE OF DEATH
5. SEX Male		5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Kit		8. DATE OF BIRTH 5/31/1884	
10a. US LABOR OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Francis J. Cannon		14. MOTHER'S MAIDEN NAME Sarah Bowditch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 18c Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO Renal cell carcinoma INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1960 to Aug. 1960, that (I) (we) last saw the deceased alive on 8-18 1960, and that death occurred at 11 A.M., from the causes and on the date stated above.		22b. DATE SIGNED 8-19-60	
22c. PHYSICIAN'S NAME (Type) H.R. TRAPNELL		22d. ADDRESS Federalsburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/60	
23c. NAME OF CEMETERY OR CREA TORY Washington		23d. LOCATION (City, town, or county) Hullock Md	
24. FUNERAL DIRECTOR'S SIGNATURE ARTHUR S. MILLINGTON, EASTERN MARKET		25a. REC'D BY REGISTRAR AUG 22 1960	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

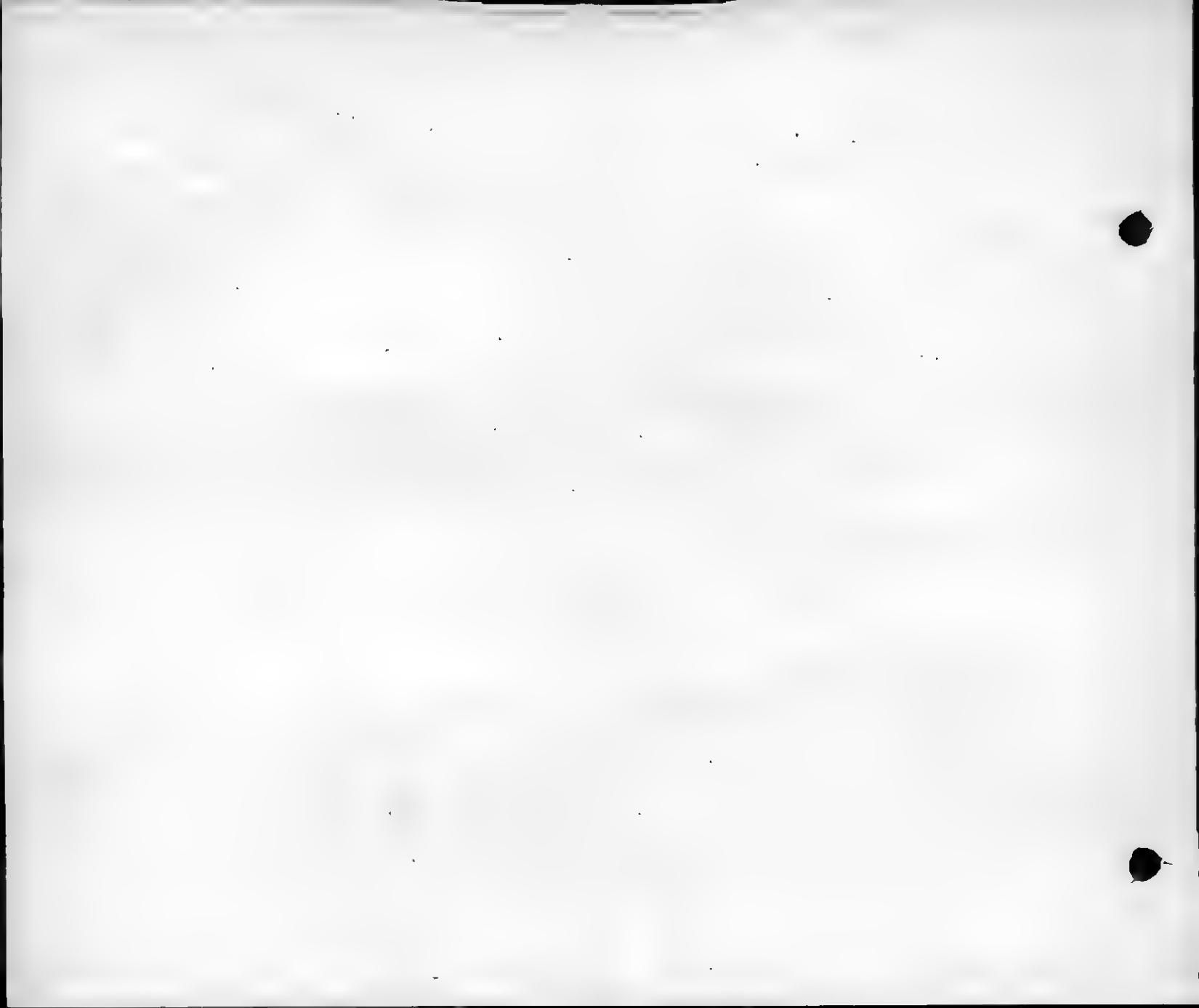
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9644

09592

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural St Michaels</i>			c. LENGTH OF STAY IN lb <i>4 yrs</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF <small>FATHER</small> (Type or print)	First <i>Magie</i>	Middle <i>Larsen</i>	Last <i>Cornelius</i>	4. DATE OF DEATH Month <i>Aug</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>F.</i>	6. COLOR OF HAIR <i>to</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>Sept. 2 1909</i>	8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <i>50</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>30</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. US JA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Day Home</i>		
11. BIRTHPLACE (State or foreign country) <i>Coloada</i>			12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		
13. FATHER'S NAME <i>Col. Charles Larsen</i>			14. MOTHER'S MAIDEN NAME <i>Christina A Petersen</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>none</i> 17. INFORMANT <i>Hector J. Cornelius, Jr. Middleway</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>25X</i> DUE TO <i>Interstitial Pulmonary fibrosis</i> INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20f. (City or town) <i>Orange</i> (County) <i>Orange</i> (State) <i>Conn.</i>	
21. I certify that (I) (We) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M. from the causes and on the date stated above					
22a. SIGNATURE <i>Elmer Schmidt</i>			22b. DATE <i>11 Aug 1960</i> SIGNED		
22c PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>			22d. ADDRESS <i>Orange, Conn.</i>		
23a. BURIAL, CREMATON OR REMOVAL (Specify) <i>cremation</i>		23b. DATE THEREOF <i>Aug 13</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Orange</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur & Sons</i>			25a. REC'D BY REGISTRAR <i>Arthur & Sons</i>		25b. REGISTRAR'S SIGNATURE
			DATE AUG 15 '60		



FOR STATE
HEALTH DEPT.

M

TO DEATH: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1959

1. PLACE OF DEATH

a. COUNTY

Talbot

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Easton

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Memorial Hospital

MARYLAND

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

2224 40TH PL N.W. WASH. D.C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

a. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

John

Hardy

Lesl

4. DATE
OF
DEATH

August 20, 1960

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

FEB. 21, 1890

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INVESTMENT BROKER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WALNUT GROVE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS CLARKE

ELLA HARDY

(Daughter)

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) -

420
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

215-10-7025 JEAN CUSHING

INTERVAL BETWEEN
ONSET AND DEATH
Star.

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF DEATH Month, Day, Year

9:35
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

8-24-60

22a. BURIAL, CREMATION
REMOVAL

8-24-60

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

LOUDON PARK CEMETERY

ADDRESS
WASH. D.C.

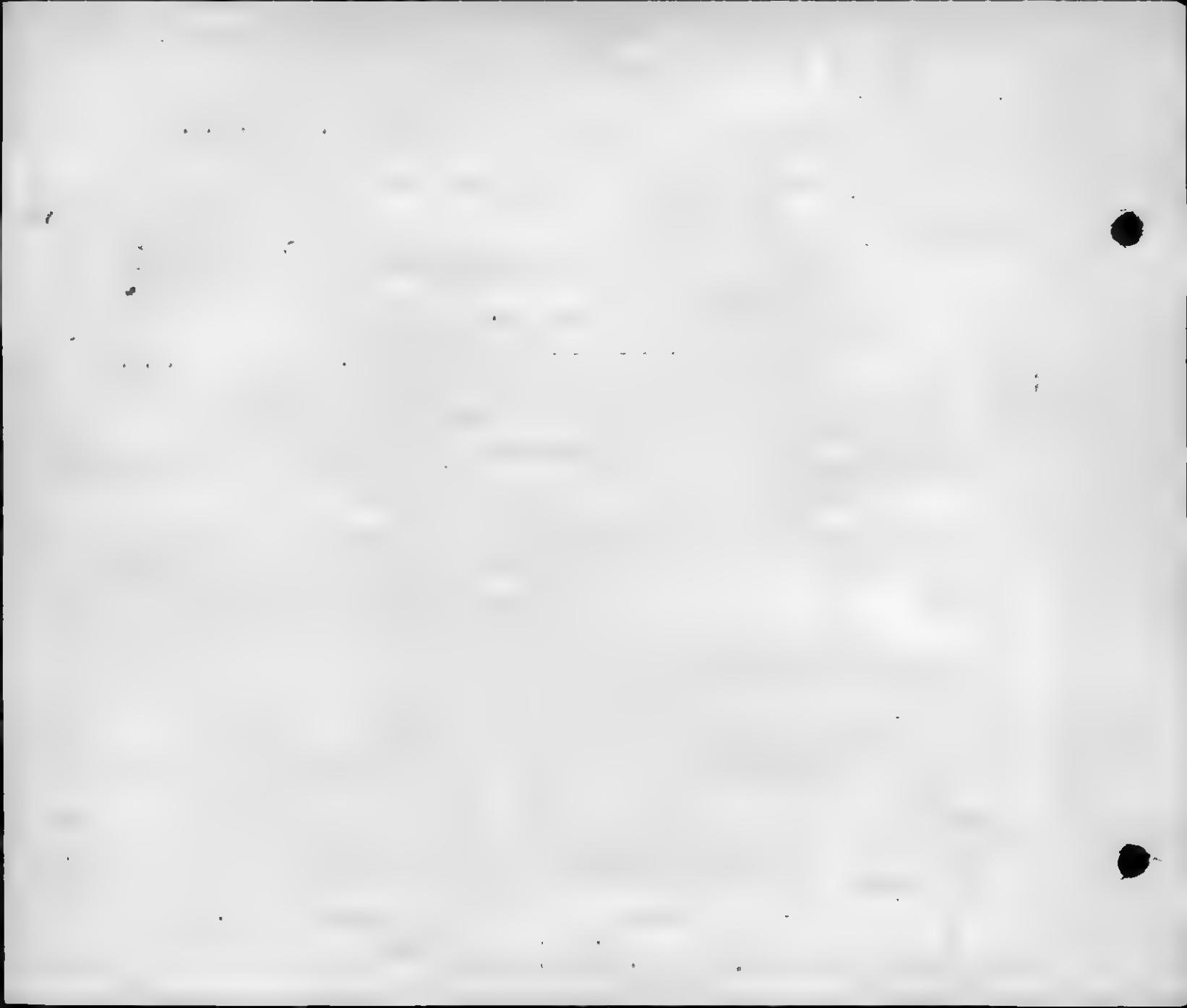
24a. FUNERAL DIRECTOR
Joseph Gawler & Sons, Inc.

JOS. GAWLER'S SONS INC.

24b. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE AUG 24 '60

C. Lewis S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9645

CERTIFICATE OF DEATH

09594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <i>MARYland</i>		b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sherwood</i>		c. LENGTH OF STAY IN 1b <i>46 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sherwood</i>		d. STREET ADDRESS <i>P.C. Box 3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Po Box 3</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Rosie E. Dennis</i>		First	Middle	Last	4. DATE OF DEATH Month <i>8</i>	Day <i>9</i>	Year <i>1960</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>50 yrs</i>		9. AGE (In years lost birthday) <i>50 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Minutes <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>		11. BIRTHPLACE (State or foreign country) <i>MARYland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Annie Mason</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>217-04-1668</i>		17. INFORMANT <i>Littleton Dennis, Sherwood, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>290.0</i>		DUE TO <i>Terminal condition</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) <i>Sherwood, Md.</i>	(County) <i>Calvert Co.</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>Aug 7, 1960</i> to <i>Aug 9, 1960</i> , that I last saw the deceased alive on <i>Aug 4, 1960</i> , and that death occurred at <i>Sherwood, Md.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Sherwood, Md.</i>		DATE SIGNED <i>Aug 11, 1960</i>			
ACTUAL SIGNATURE <i>GUY M REESER, M.D.</i>		PHYSICIAN'S NAME (Type) <i>GUY M REESER, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/11/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Sherwood Cem.</i>		22d. LOCATION (City, town, or county) <i>Sherwood, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jewell L. Nichols, Easton, Md.</i>		ADDRESS <i>Jewell L. Nichols, Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 17 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Thomas</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

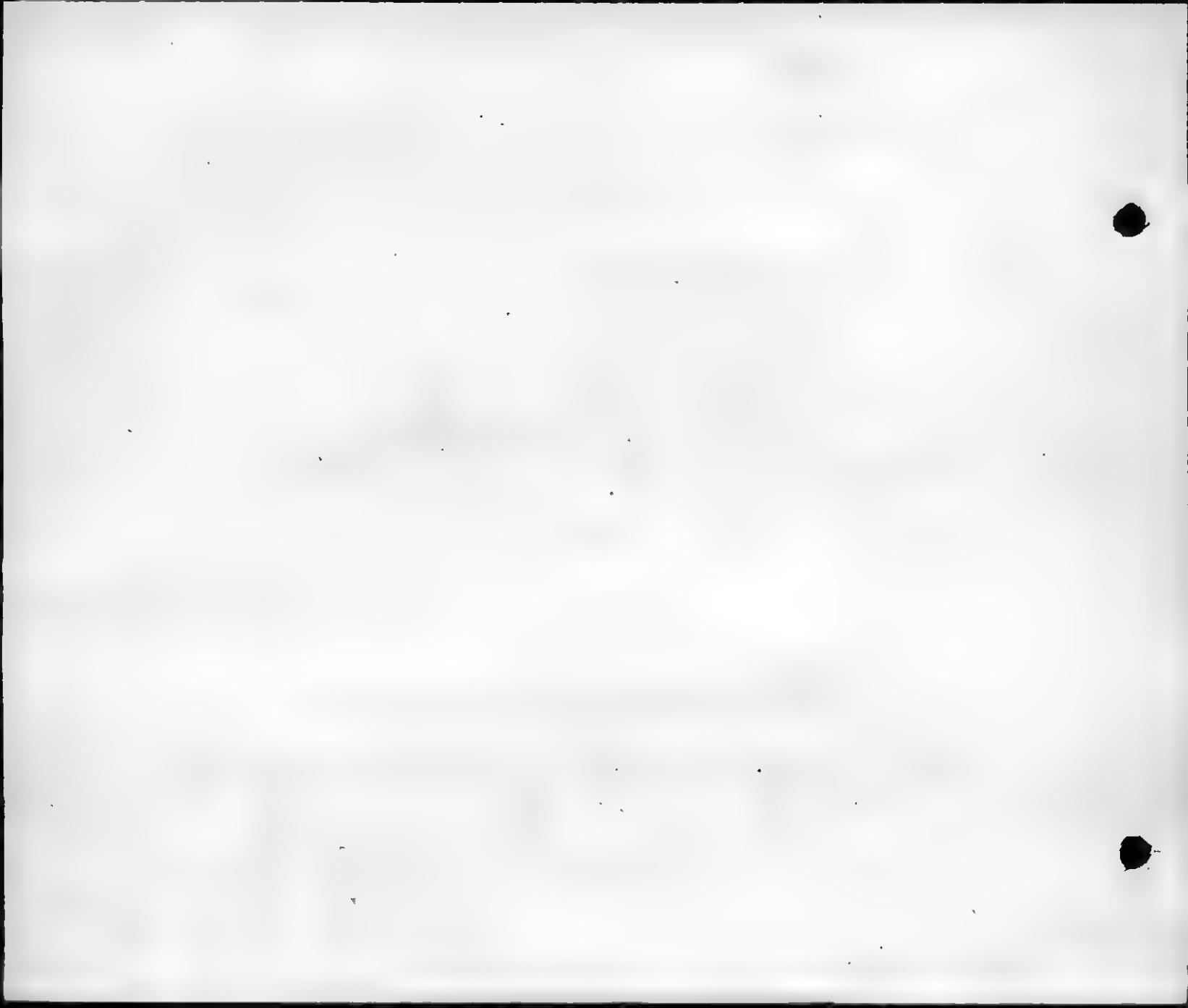
VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

119595

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>19 hr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hickman</i>		d. STREET ADDRESS <i>15 x-1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Rosa</i>	Middle <i>May</i>	Last <i>Drummond</i>	4. DATE OF DEATH	Month <i>Aug</i>	Doy <i>22</i>	Year <i>1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept 12, 1903</i>	9. AGE (In years last birthday) <i>58 yrs.</i>	F UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS Days <i>22</i>	Year Hours Min. <i>00</i>
10a. USL AL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY during last of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Home</i>		12. CITIZEN OF WHAT COUNTRY? <i>England</i>			
13. FATHER'S NAME <i>John Hobson</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Jordan</i>		Address <i>Quinn Drummond, S. 10th Street</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>342K</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <i>2 years abcess, left temporal</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Concord</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____ and that death occurred on _____ M. from the causes and on the date stated above.		19. to 19. that (I) (we) last saw the deceased alive on _____ and that death occurred on _____ M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Bellah Schmidt</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE 22 Aug 1960			
22c. PHYSICIAN'S NAME (Type) <i>F. C. H. Schmidt</i>		22d. ADDRESS <i>Easton, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated</i>		23b. DATE THEREOF <i>Aug 25, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Concord</i>		23d. LOCATION (City, town, or county) (State) <i>Concord, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>G. J. Morris & Son</i>		ADDRESS <i>Easton, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 29 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9621

CERTIFICATE OF DEATH

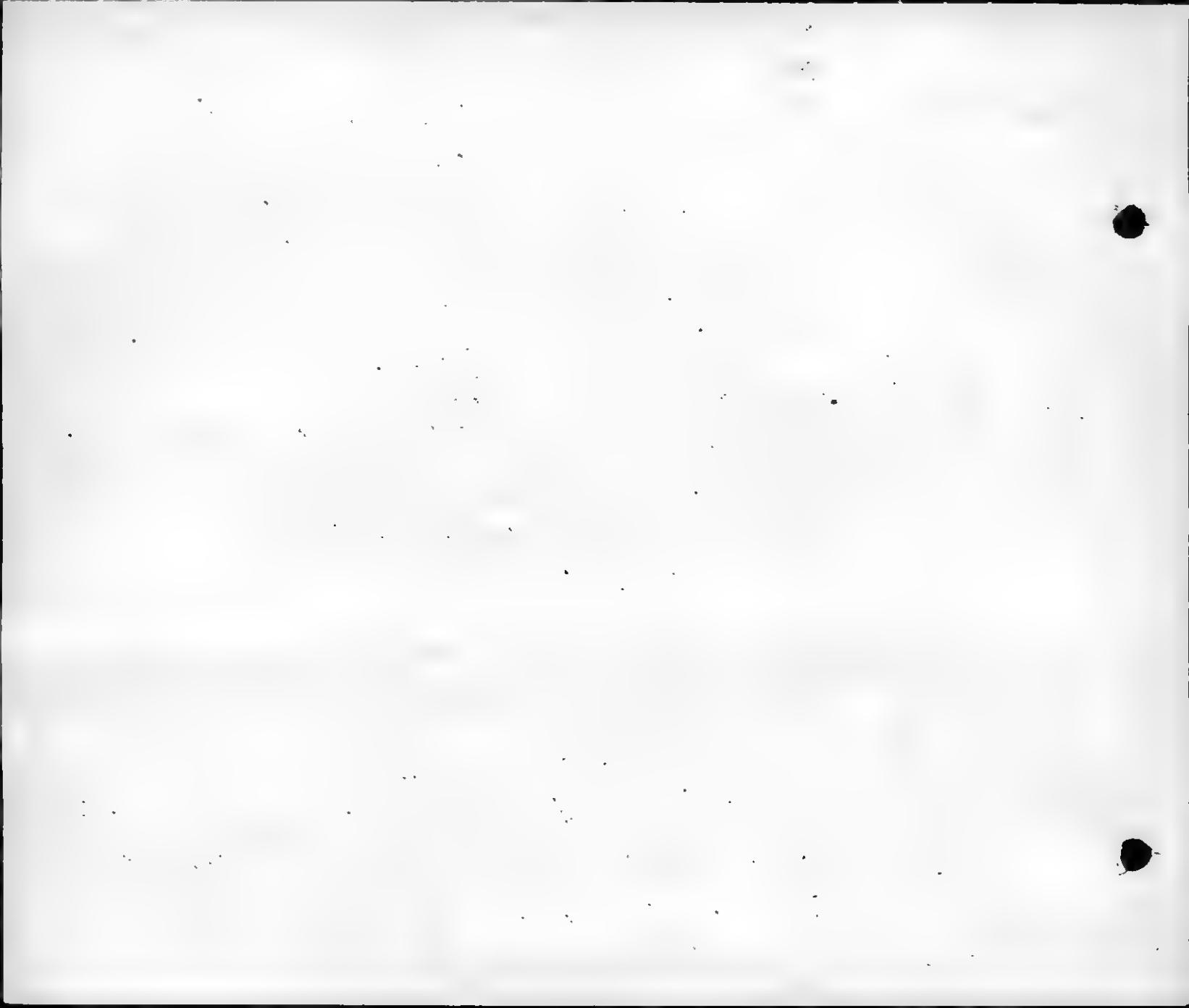
119596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
3. NAME OF DECEASED (Type or print) Ola		First Ola	Middle Nevell
4. DATE OF DEATH Dyott		Last Dyott	Month August
5. SEX F.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 1, 1900		9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Our Home	10c. BIRTHPLACE (State or foreign country) Newfane
11. CITIZEN OF WHAT COUNTRY? A.O.G.		12. CITIZEN OF WHAT COUNTRY? A.O.G.	
13. FATHER'S NAME Ernest W. Collins		14. MOTHER'S MAIDEN NAME Amy Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 770-26-1066	
17. INFORMANT Ernest Lee Dyott		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Date pernity	
(b) DUE TO Strangulated hernia		Obesity	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 7:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. L. Schmidt		ADDRESS (Street, city or town, state) 219 S. Washington St., Easton, Maryland	
PHYSICIAN'S NAME (Type) E. L. Schmidt		DATE SIGNED Aug 10 1960	
22a. BLR AL/CREMATION, REMOVAL (Specify) None		22b. DATE THEREOF Aug 9, 60	
22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill		22d. LOCATION (City, town, or county) Easton	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Lewis		24a. REC'D BY REGISTRAR Charles E. Lewis	
ADDRESS Easton, Maryland		24b. REGISTRAR'S SIGNATURE Charles E. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09597

M

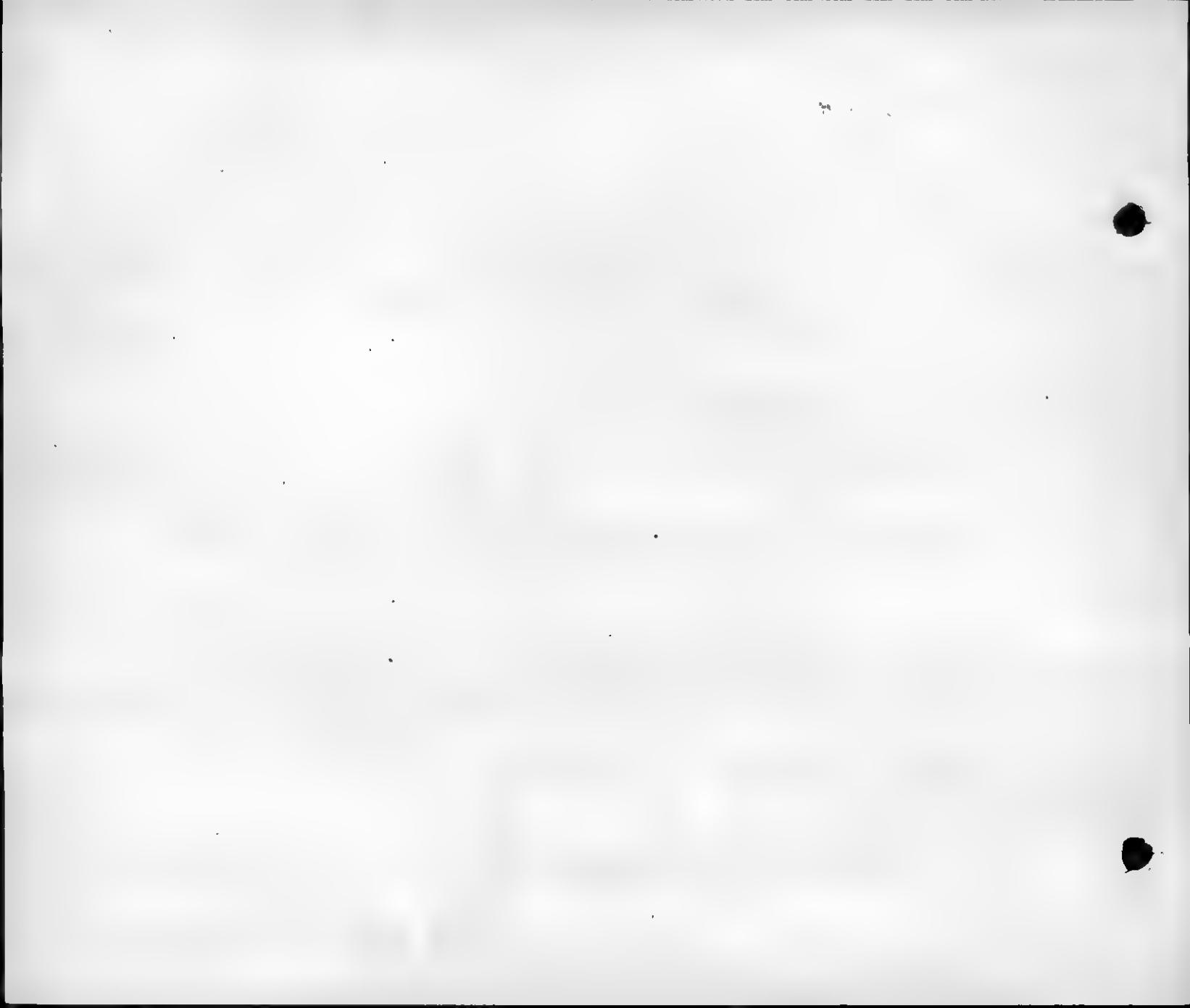
9629

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Talbot				o. STATE <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY <u>TALBOT</u>	
<u>EASTON</u>		<u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Memorial Hospital		1 307 NORTH			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
James		J	M	Emerson	August 21 1960
S. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years last birthday) yrs
<u>M.</u>		<u>W.</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>Nov 27, 1888</u>	<u>71</u>
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TICKET AGENT		THEATER		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
W. J. Emerson		MARY ANN DONLIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
No		MC-32-9826		MRS KATHERINE B. EMERSON, EASTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<u>acute gastric & intestinal</u>			
541.1		<u>obstruction & dilatation</u>			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Supra-pubic prostate					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		22b. DATE <u>21 Aug 1960</u>			
22a. SIGNATURE <u>John Schmitt</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>	
23a. Cremation, Removal (Specify) <u>Aug 24, 60</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Bethel Cemetery</u>		23d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Schmitt</u>		ADDRESS <u>Easton Md</u>		25a. REC'D BY REGISTRAR <u>AUG 24 60</u> DATE <u>AUG 24 60</u>	
				25b. REGISTRAR'S SIGNATURE <u>John S. Thorne</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9646 CERTIFICATE OF DEATH										19598	
1. PLACE OF DEATH a. COUNTY Talbot					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					Reg. Dist. No.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton					b. COUNTY Talbot						
c. LENGTH OF STAY IN 1b Life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 450 Route 3					d. STREET ADDRESS Box 450 Route 3					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)		First ALBERTHA	Middle LONG	Last EVANS	4. DATE OF DEATH AUG. 7 1960		Month AUG.	Day 7	Year 1960		
5. SEX Female		6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25		9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS Days 15	12. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Robert Johnson			14. MOTHER'S MADDEN NAME MARtha Ann Foster			INFORMANT George Evans, Easton, Md.			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO —			17. INTERVAL BETWEEN ONSET AND DEATH 4 HRS.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. 19 p. m. —			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) — (State) —		
21. I certify that I attended the deceased from 8-11 1960 to 8-7 1960 , that I last saw the deceased alive on 8-7 1960 , and that death occurred at 8 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Donald F. Hartley ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON MD. DATE SIGNED 8-9-60											
PHYSICIAN'S NAME (Type) Donald F. Hartley EASTON MD.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 8/12/68			22c. NAME OF CEMETERY OR CREMATORIAL RICHARD'S Cem			22d. LOCATION (City, town, or county) EASTON (State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE James D. Lambeth, Easton, Md.			ADDRESS			24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE		
						DATE AUG 10 1968					

and

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9647

CERTIFICATE OF DEATH

09599

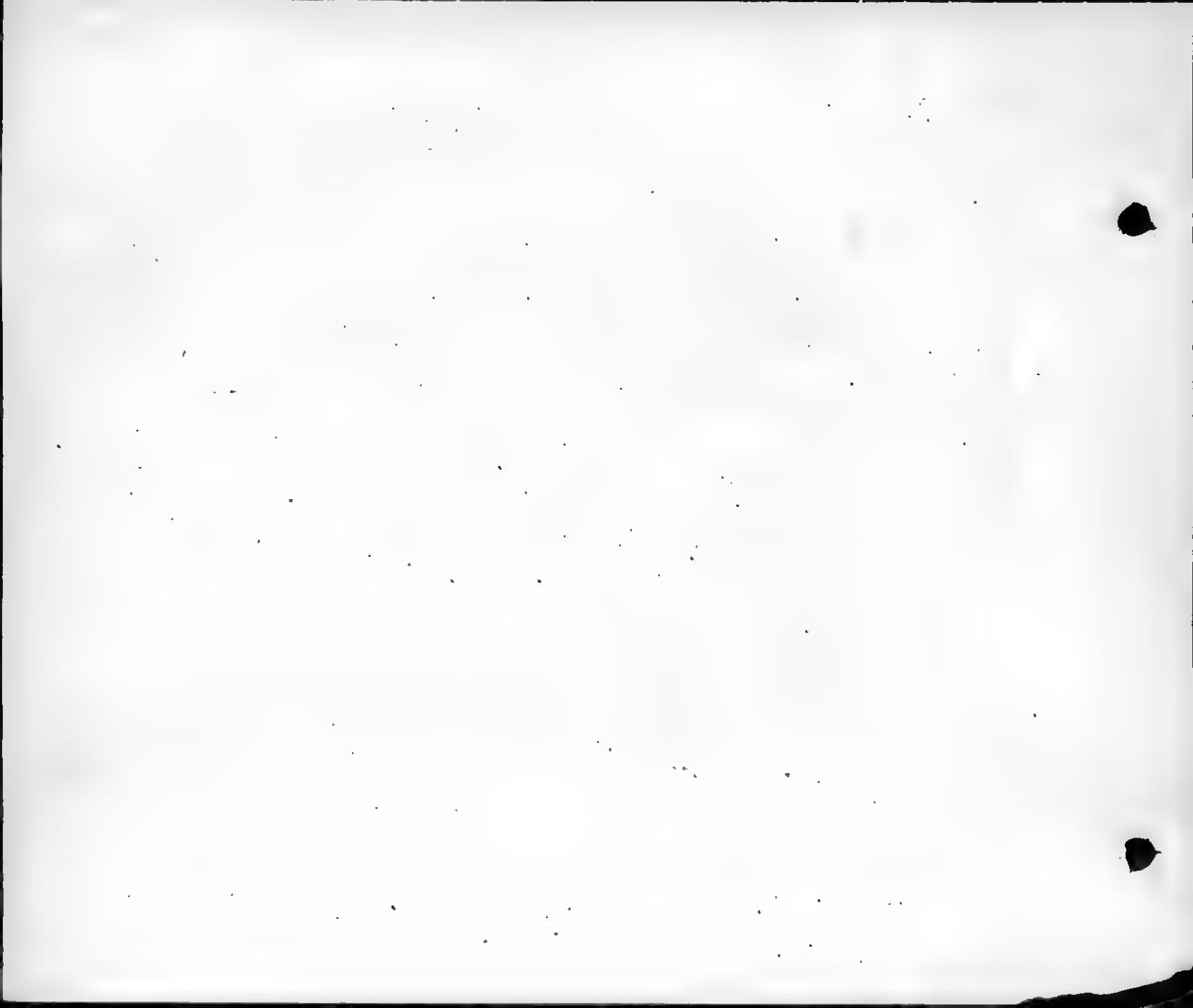
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS (RURAL)		c. LENGTH OF STAY IN 1b 6 MO.		
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION RIO VISTA NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ALVERDA	Middle 	Last GAREY	
4. DATE OF DEATH	Month AUGUST	Day 17	Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY. 20, 1880	
9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. Hours 	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DELAWARE
13. FATHER'S NAME CHARLES-WARRINGTON		14. MOTHER'S MAIDEN NAME SARAH-E-COLLINS		12. CITIZEN OF WHAT COUNTRY? J. S.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. WARRINGTON-GAREY		Address EASTON MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.				
DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hypertension Cardiac Vasculitis				
INTERVAL BETWEEN ONSET AND DEATH 5 MIN.				
DUE TO (c) Diabetes Mellitus				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5 Feb , 19 60 to 17 Aug , 19 60 , that I last saw the deceased alive on 10 Aug , 19 60 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Bell 487, St. Michaels, Md.		DATE SIGNED 8-18-60
22a. BURIAL, CREMATION, Crematory BURIAL		22b. DATE THEREOF AUG. 19, 1960		22c. NAME OF CEMETERY OR CREMATORIUM SPRING HILL CEM.
22d. LOCATION (City, town, or county) EASTON MD.		24a. REC'D BY REGISTRAR DATE AUG 19 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Trahan
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son		ADDRESS Easton Md.		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

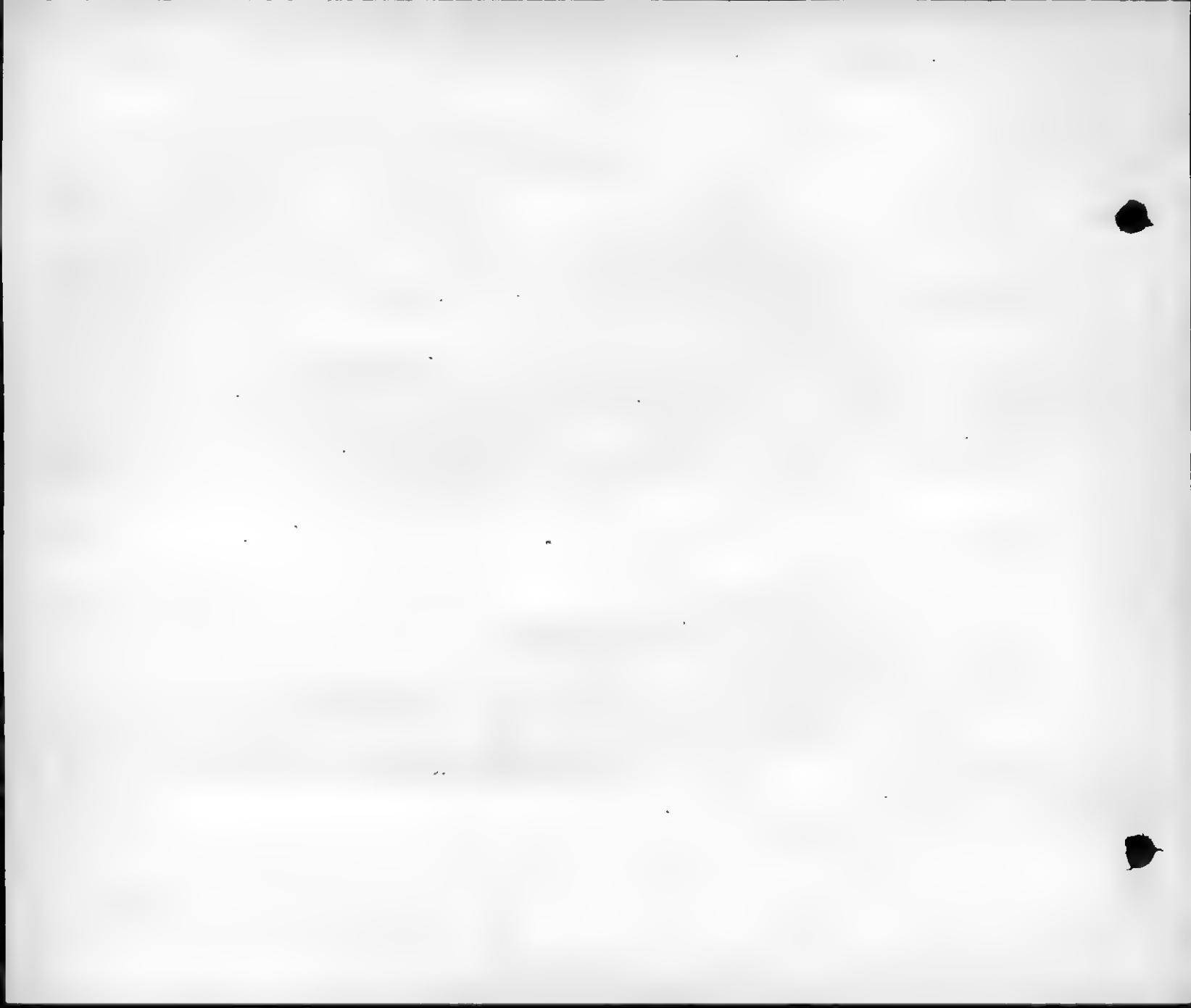
9623

09600

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Talbot</i> MARYLAND		<i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>EASTON</i>	<i>32 da.</i>	<i>EASTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Memorial Hospital</i>		<i>617 Golosson St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Last	Month
<i>Ada</i>	<i>foreman</i>	<i>Golt</i>	<i>Aug</i>
4. DATE OF DEATH	Day	Year	
<i>Aug. 9, 1890</i>	<i>18</i>	<i>1960</i>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>FEMALE</i>	<i>WHITE</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>Aug. 9, 1890</i>
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min
<i>70 yrs</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>HOUSEWORK</i>		<i>HOUSEWIFE</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>MARYLAND</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Edward E. Foreman</i>		<i>Annie E. Frampton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
<i>NONE</i>		<i>UKN.</i>	
17. INFORMANT		Address	
<i>Mrs. Daville H. Dyer, Easton, MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a)		<i>Cerebral Thrombosis</i> <i>acute</i>	
<i>45x</i>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		<i>Hypertensive Arteriosclerotic Cerebral Vascular Disease</i> <i>years</i>	
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Acute Renal failure</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/27/60</i> to <i>8/18/60</i> , that (II) (we) last saw the deceased alive on <i>8/18/60</i> , and that death occurred at <i>Easton</i> , M.D., from the causes and on the date stated above.		22b. DATE SIGNED <i>8/18/60</i>	
22a. SIGNATURE <i>L.J. Egleder</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>L.J. Egleder</i>		22d. ADDRESS <i>Easton, MD.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>8/20/60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>		23d. LOCATION (City, town, or county) <i>Easton, MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. G. Gaynor Carroll, Easton, MD.</i>		ADDRESS	
		25a. REC'D BY REGISTRAR <i>John S. Evans</i>	
		25b. REGISTRAR'S SIGNATURE	
		DATE <i>AUG 22 '60</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

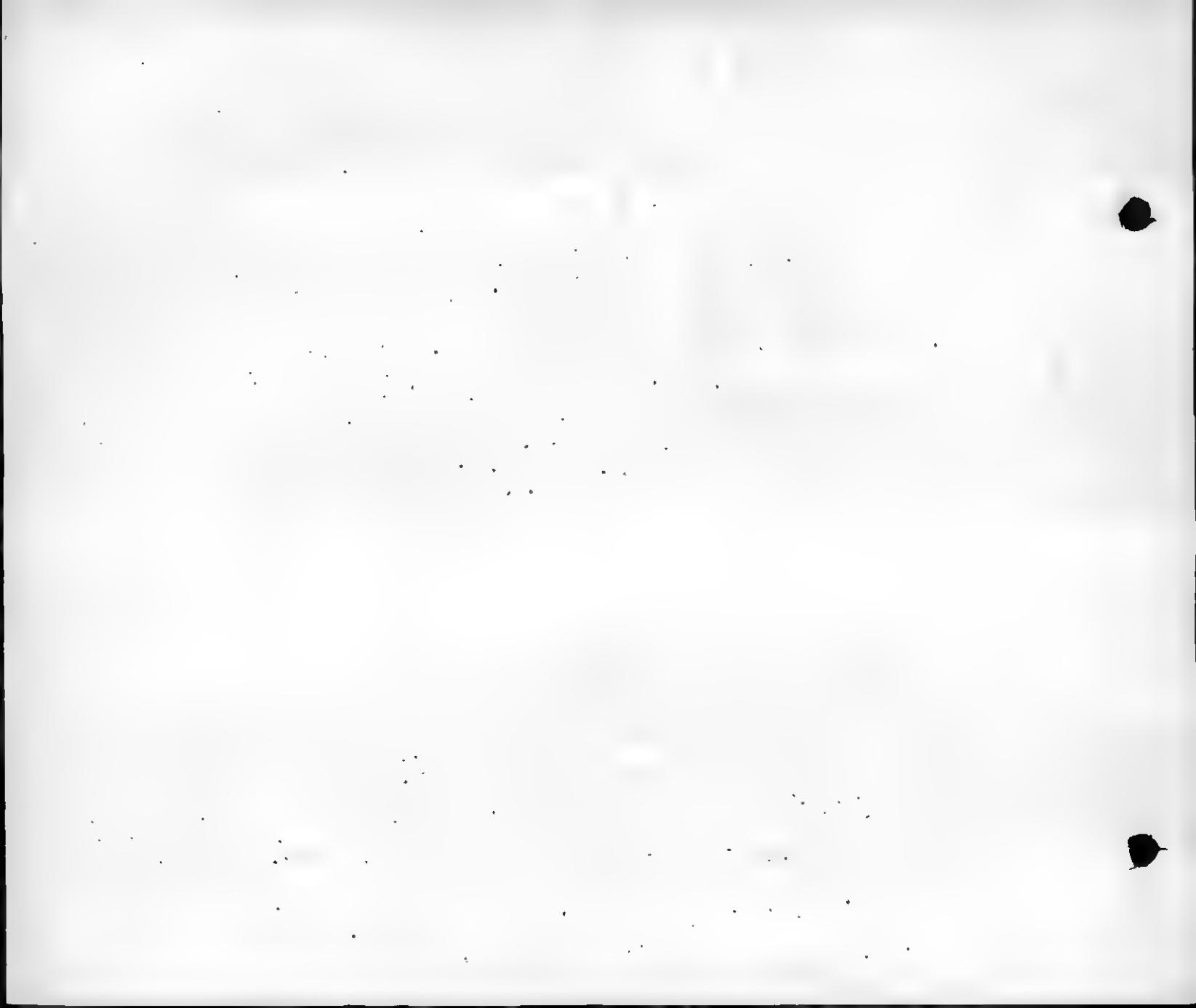
9624

CERTIFICATE OF DEATH

09601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived if institutional, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 20 hrs. 15 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		e. STREET ADDRESS 15X2 Denton	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Wealey Harris		4. DATE OF DEATH Month Aug 2 1960	Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 24, 1874
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES HARRIS	
14. MOTHER'S MAIDEN NAME ELIZABETH ANN FLOWERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Wife Lewis Henry Denton, Md.		INFORMANT Mrs Lewis Henry Denton, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 70.5		INTERVAL BETWEEN ONSET AND DEATH 0	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 0		DUE TO 0	
(c) 0		DUE TO 0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 0	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 0		20f. (City or town) (County) (State) 0	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E.C.H. Schmidt		ADDRESS (Street, city or town, state) 219 E. Washington St. Denton, Md.	
PHYSICIAN'S NAME (Type) E.C.H. Schmidt		DATE SIGNED Aug 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 5, 1960		22b. DATE THEREOF 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Denton		22d. LOCATION (City, town, or county) (State) Denton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Virginio Moore Son Denton, Md.		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
ADDRESS 0		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
FOR STATE
HEALTH DEPT.

M

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09602

1. PLACE OF DEATH

a. COUNTY

Talbot

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Newcomb

c. LENGTH OF STAY IN 1B

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Oak Creek

3. NAME OF
DECEASED
(Type or print)

First

Middle

WILLIAM

5

Last
Holland

4. SEX

MALE

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE
OF
DEATH

JUNE 26, 1953

9. AGE (In years
last birthday)

7 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Douglas Holland

14. MOTHER'S MAIDEN NAME

Louise Sedgwick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war record of service)

17. INFORMANT

Address

Mrs Douglas Holland, nee Louise Sedgwick

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

904.8

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Accidental drowning

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AN AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Drowned in creek - swimming

20c. TIME OF INJURY Month, Day, Year
Hour _____ p.m. 8-27 1960

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office, bridge, etc.)

20f. (City or town) (County)
Oak Creek Tal. Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

8-27-60

22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF
Burial 8-30-60

22c. NAME OF CEMETERY OR CREMATORIUM

Springhill Cemetery

22d. LOCATION (City, town, or country)
(State)

Easton Md

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

J. Hamilton Harrison, El. Michigan

DATE SEP 2 '60

Charles S. Kraus

V.S. A15ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09603

1. PLACE OF DEATH a. COUNTY		9625 Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b EASTIN 35 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Caroline Preston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		55 S.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Luther Herman Lee				August	19	1960	

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
M	W		Oct 30, 1910	49 yrs.	Months Days	Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver	Trucking	Pennsylvania	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob F. Lee	Elvira Cleverger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mrs. Luther Lee	Roston, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis	acute illness thru liver
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
DUE TO	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--	--

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that (I) (this hospital) attended the deceased from 17 Aug 1960 to 18 Aug 1960, that (I) (we) last saw the deceased alive on 17 Aug 1960, and that death occurred about 11 AM, from the causes and on the date stated above	22b. DATE SIGNED
	18 Aug 60

22c. PHYSICIAN'S NAME (Type)	M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
THURSTON HARRISON			Cast. Henry Ford

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town, or county) (State)
Burial	Aug 23, 1960	Denton	Denton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Virgil Moore	Denton, Md.	AUG 29 '60	Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

119604

9626

CERTIFICATE OF DEATH

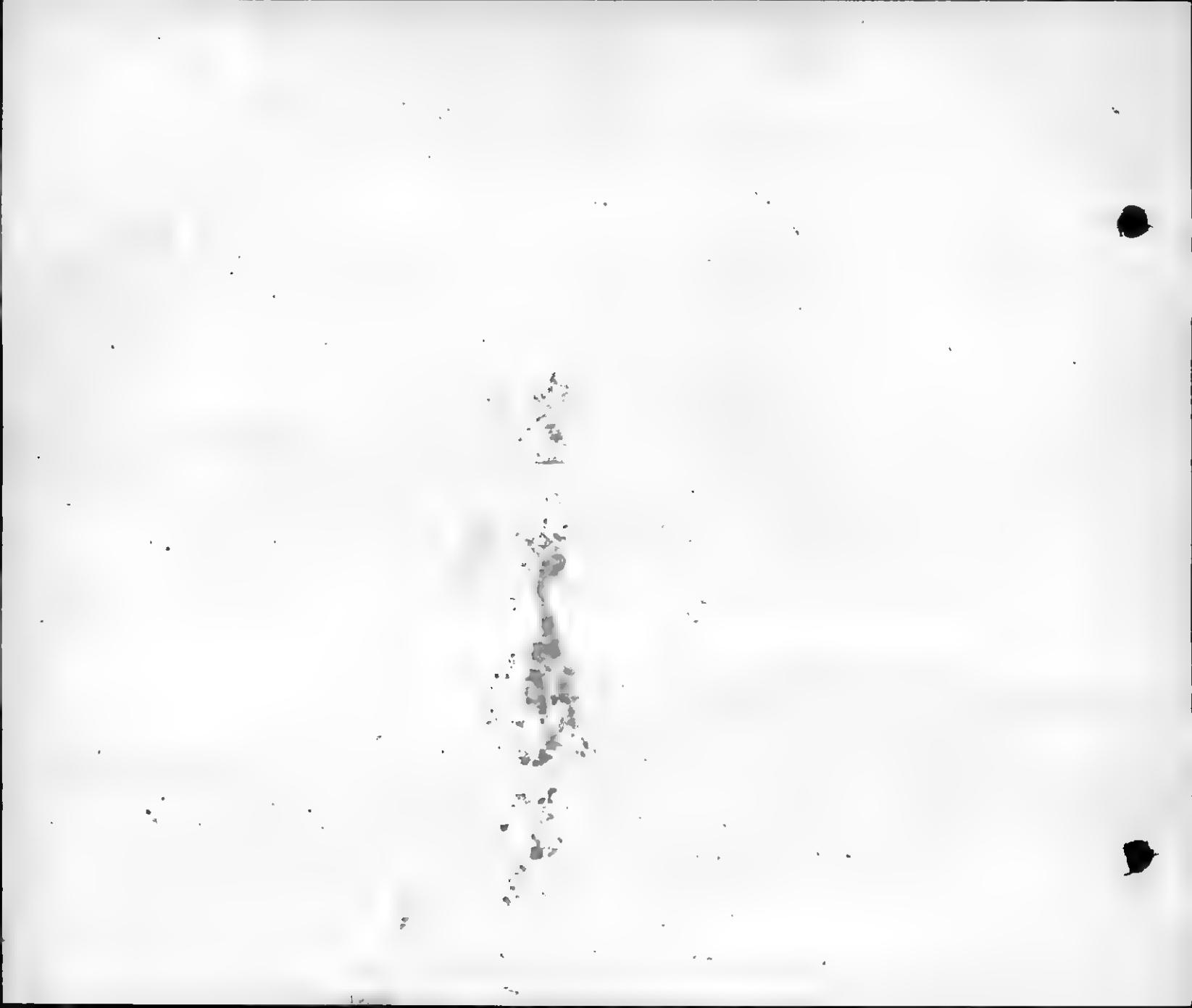
Reg. Dist. No.

after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>4 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Lawrence</u>	Middle <u>Henry</u>	Last <u>Malin</u>
4. DATE OF DEATH	Month <u>Aug</u>	Day <u>1</u>	Year <u>1960</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 4, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>APPLIANCE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILLIAM MALIN</u>	14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	INFORMANT <u>MRS CATHERINE CORISTIN, Newcastle, MD.</u>	Address <u>—</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u>			
DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertension, Cardiac Vasculitis, 10 yrs.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>a. m.</u> <u>p. m.</u>	Month <u>July</u> <u>19</u>	20d. INJURY OCCURRED While <u>at work</u> <input type="checkbox"/> Not while <u>at work</u> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>Baltimore</u>	(County) <u>Maryland</u>	(State) <u>Md.</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <u>25 July</u> , 19 <u>60</u> , to <u>1 Aug</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1 Aug</u> , 19 <u>60</u> , and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>R. Lane W. Roth</u>	ADDRESS (Street, city or town, state) <u>Box 489, St. Michaels, Md.</u> DATE SIGNED <u>8-2-60</u>		
POLICE SUSPECT NAME (Type) <u>R. Lane W. Roth</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-4-60</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Flemington Cemetery</u>	22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Lane W. Roth</u>	ADDRESS <u>101 Franklin & Harrison St. Milwaukie</u>	24a. REG'D. BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>
VS A15 (4) ISM 9/58	DATE <u>AUG 5 '60</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

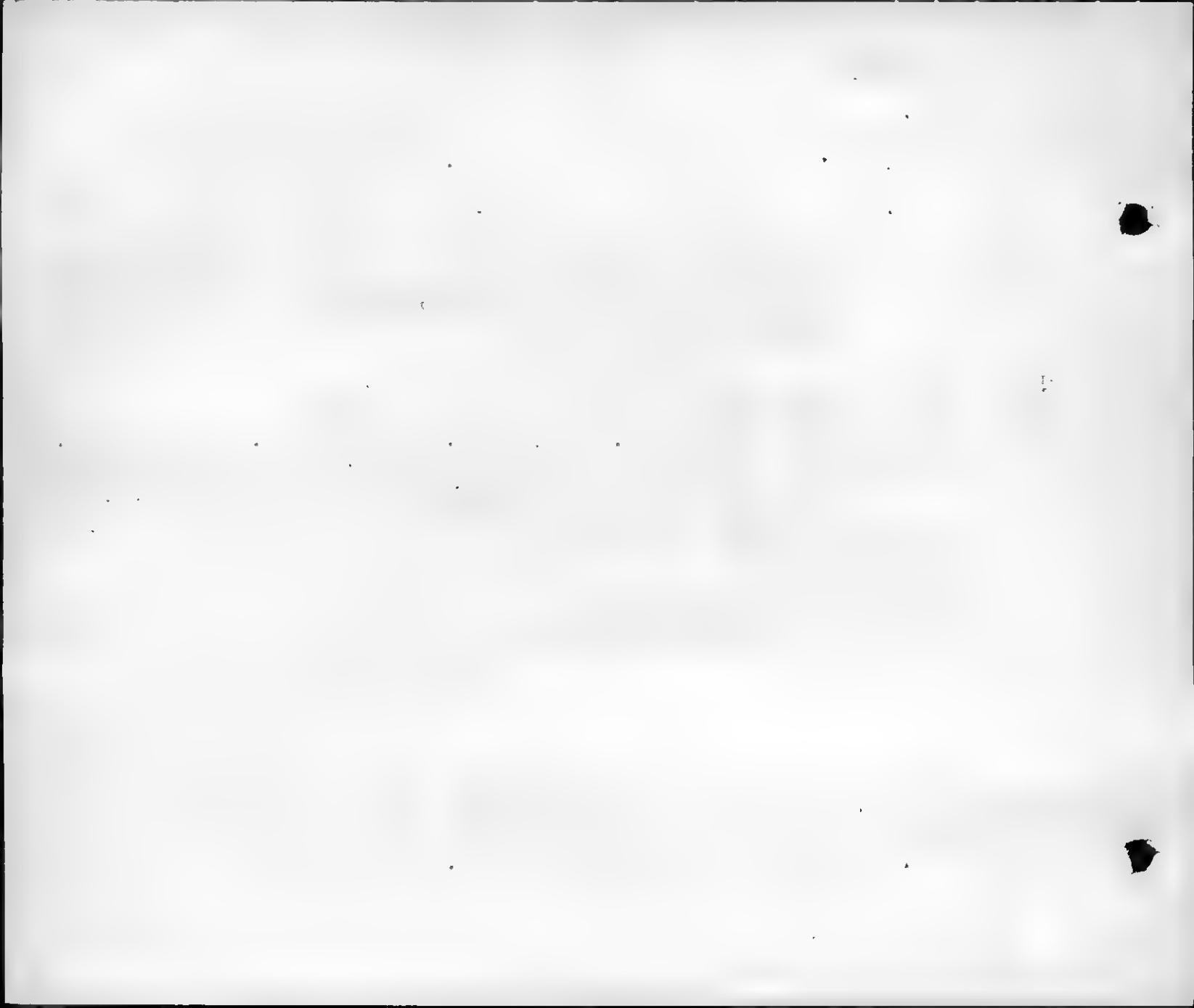
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09605

CERTIFICATE OF DEATH

9627			
1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 4 hrs 45 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels,	
3. NAME OF DECEASED (Type or print) Jesse		First Norman	Middle Marshall
3. NAME OF DECEASED (Type or print) Jesse		Last Marshall	4. DATE OF DEATH 8 - 20 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 6, 1885
9. AGE (In years last birthday) 75 yrs.		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marshall's Express		10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Jesse Marshall		14. MOTHER'S MAIDEN NAME Celia Willis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. u kn.	17. INFORMANT Norman D. Marshall, St. Michaels, Md.
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, ast (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6-7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastritis Enteritis etiologic?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 8-17 1960 to 8-20 1960	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) St. Michaels (County) Maryland (State) Maryland
21. I certify that (I) (this hospital) attended the deceased from 8-17 1960 to 8-20 1960 that (I) (we) last saw the deceased alive on 8-20 1960 and that death occurred at 4:30 PM , from the causes and on the date stated above.		22b. DATE SIGNED 8-20-60	
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Michaels, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Langton Conard		25a. REC'D BY REGISTRAR DATE AUG 23 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Knue



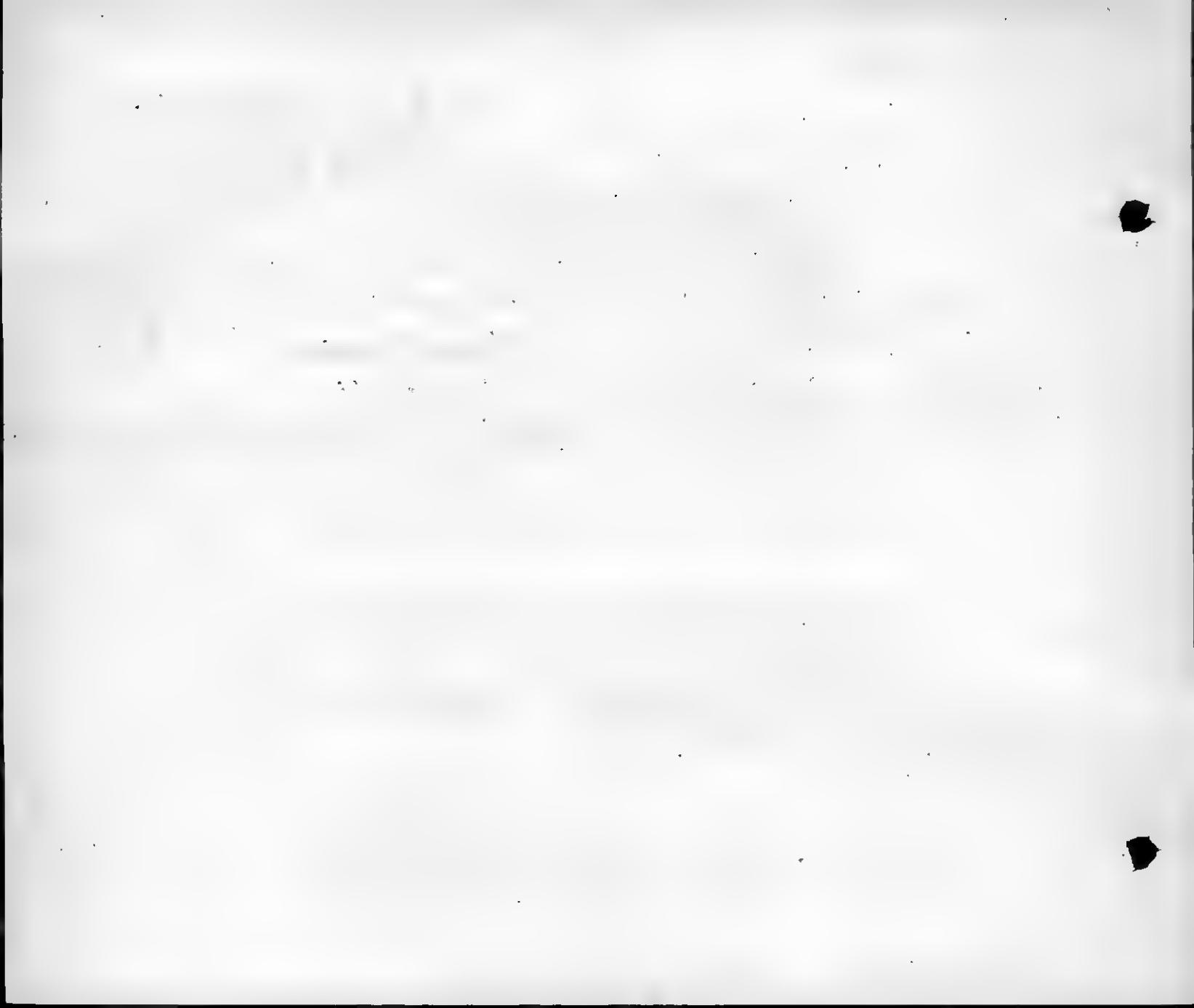
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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09607

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna Charlotte Newnam		First	Middle	Last	4. DATE OF DEATH August 28 1960	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MAR 22 1880	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEAVITT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Niblett		14. MOTHER'S MAIDEN NAME Elizabeth Parks		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service —		16. SOCIAL SECURITY NO. 17. INFORMANT Address McCoy Newnam, at Michael's		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO H. H. L. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Nephrosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH < 3 weeks.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at 3:22 P.M. , from the causes and on the date stated above		22a. SIGNATURE Robert W. Trevor		M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/30/60	
22c. PHYSICIAN'S NAME (Type) Robert W. Trevor		22d. ADDRESS Easton, Maryland				22e. LOCATION (City, town or county) Neavitt (State) Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 31, 1960		23b. DATE THEREOF Aug 31, 1960		23c. NAME OF CEMETERY OR CRYPTORY Neavitt Cemetery		23d. LOCATION (City, town or county) Neavitt (State) Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Hamilton Harrison, St. Michaels		ADDRESS St. Michaels		25a. REC'D BY REGISTRAR DATE SEP 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09606

9629

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		d. STREET ADDRESS Rt # 3 Box 303	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE MEMORIAL Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Timothy	Middle —	Last NEWMAN	4. DATE OF DEATH August 12 1960	Month	Day	Year
5. SEX m	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 7, 1910	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY LANDSCAPING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hebrew Newman		14. MOTHER'S MAIDEN NAME MARY ELLEN Hawkins		Address Centreville, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-4521		17. INFORMANT Mrs. Eliza Newman		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia, right lobe	
						INTERVAL BETWEEN ONSET AND DEATH	
						 Mephritis, b. history	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____ and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE DeLoach		M.D. ATTENDING PHYSICIAN F.C.H. Schmidt		22b. DATE Aug 14 1960			
22c. PHYSICIAN'S NAME (Type) Dr. E. C. H. Schmidt		22d. ADDRESS Centreville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 14, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Earle's Chapel Cemetery		23d. LOCATION (City, town, or county) (State) Rural Centreville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Jones & Baileys of Baileys Bar, Centreville, Md.		ADDRESS ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 16 '60		25b. REGISTRAR'S SIGNATURE John S. Kenna	

682/

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

119698

FOR STATE
HEALTH DEPT.
M

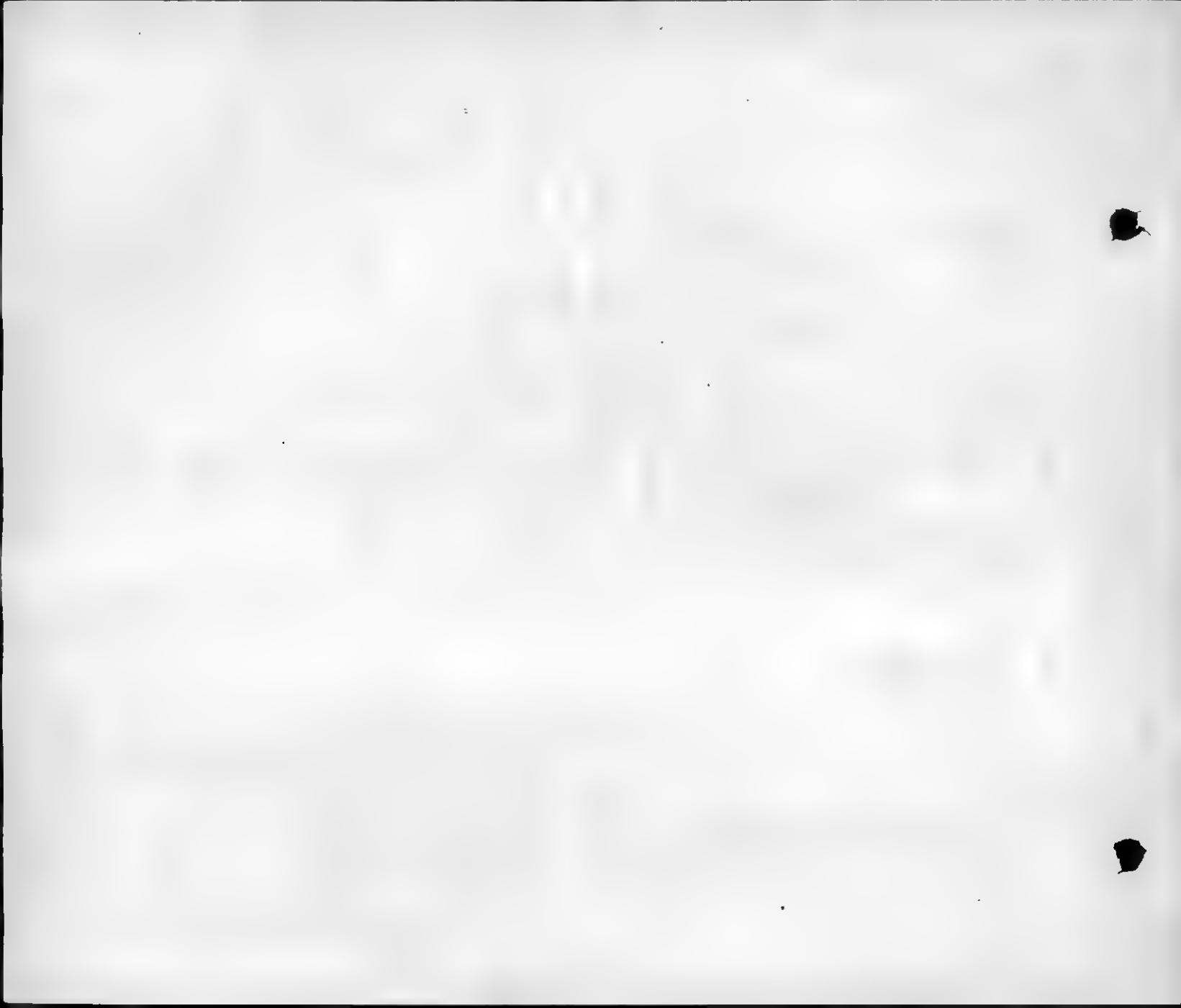
Reg. Dist. No.

9649

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

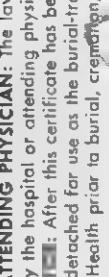
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND , COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL) EASTON RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON RURAL	
d. LENGTH OF STAY IN lb 3 mo.		e. STREET ADDRESS ✓	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Wesley	Last Paluck
4. DATE OF DEATH	Month August	Year 1960	Day 14
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 11, 1894
9. AGE (In years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOSIERY MACHINE WORKER		10b. KIND OF BUSINESS OR INDUSTRY Mill	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? C. Z.	
13. FATHER'S NAME Anthony Paluszkiwicz		14. MOTHER'S MAIDEN NAME (Unknown) Borszna Poland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO. 217-07-8592	
17. INFORMANT W.W.I		Address Mrs James Price	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.		INTERVAL BETWEEN ONSET AND DEATH CRONARY Occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year 7:30 a.m. 8-14 1960		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ✓	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20d. (City or town) Caston (County) MD (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Karen D'Healy		DATE SIGNED 8-14-60	
EXAMINER'S NAME (Type) WELTY		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION BURN (Check one)		22b. DATE THEREOF Aug. 16, 1960	
22c. NAME OF CEMETERY OR Crematory Spring Hill Cemetery		22d. LOCATION (City, town, or county) Caston (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Marie L. Brown & Son, Inc., Caston, Md.		24a. REC'D BY REGISTRAR Aug 16 '60	
ADDRESS ✓		24b. REGISTRAR'S SIGNATURE Cecilia S. Price	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1



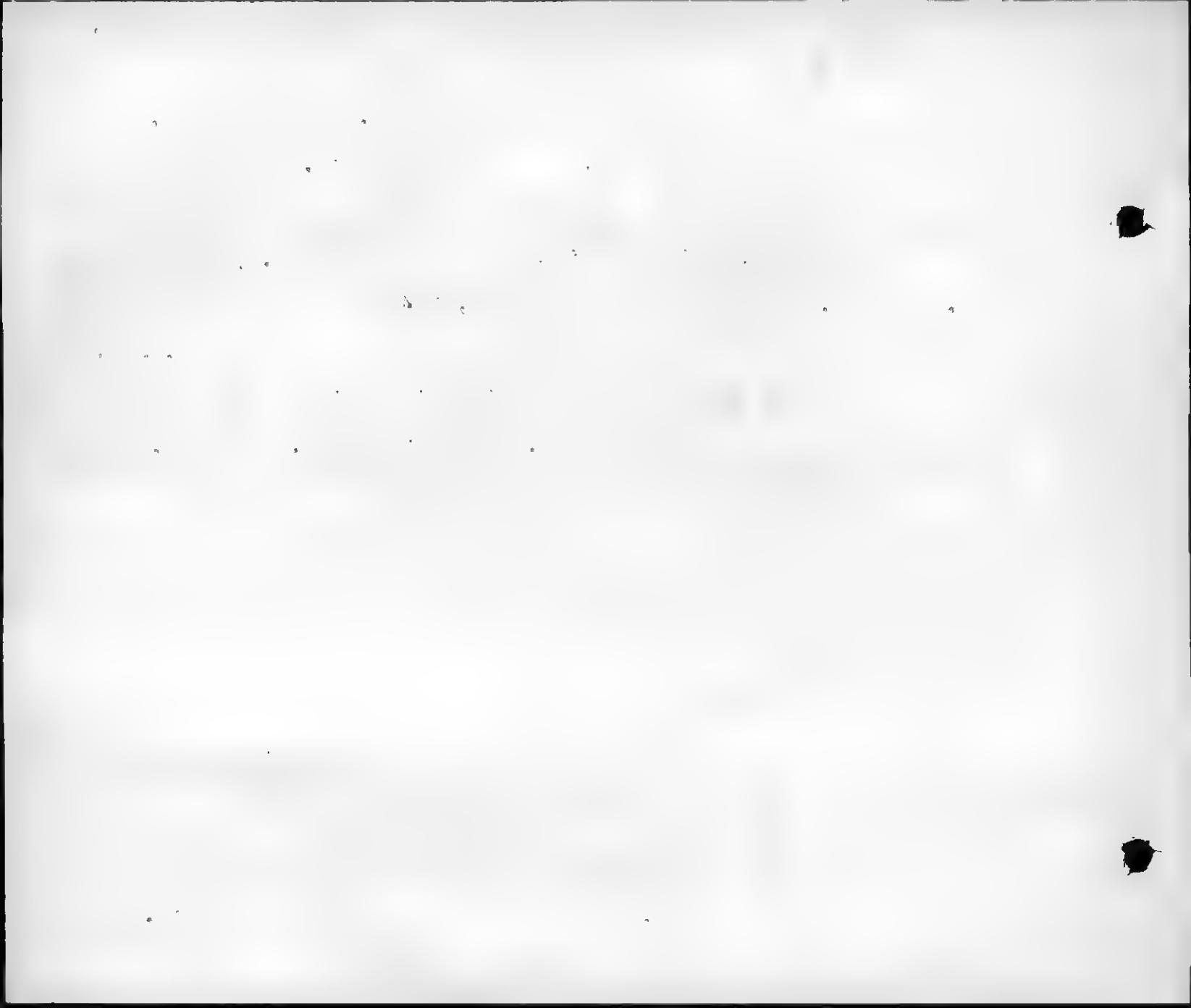
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09669

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) c. LENGTH OF STAY IN 1b MARYLAND Maryland.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oxford.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Oxford		c. LENGTH OF STAY IN 1b 90 yrs.		d. STREET ADDRESS X Rural Oxford.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								
3. NAME OF DECEASED (Type or print)		First Sophia	Middle Derrickson	Last Ritter	4. DATE OF DEATH Aug. 3, 1960	Month Aug.	Day 3	Year 1960
5. SEX F.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1870		9. AGE (In years last birthday) 90 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.		
13. FATHER'S NAME James Harrison Willis		14. MOTHER'S MAIDEN NAME Virginia Louise Harris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT R. Heber Ritter Jr.		Address Oxford.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X		DUE TO Cerebral arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH (?)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 1949 to 3 Aug. 1960 , that (I) (we) last saw the deceased alive on 3 Aug. 1960 , and that death occurred at Oxford , M., from the causes and on the date stated above.								
22a. SIGNATURE Thorston Harrison		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5 Aug 60				
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22d. ADDRESS Caston Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 6, 1960.		23c. NAME OF CEMETERY OR CREMATORIAL Oxford.		23d. LOCATION (City, town, or county) Oxford, Maryland. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Richard Easton Jr.		ADDRESS Caston Rd		25a. REC'D BY REGISTRAR Aug 10 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

CERTIFICATE OF DEATH

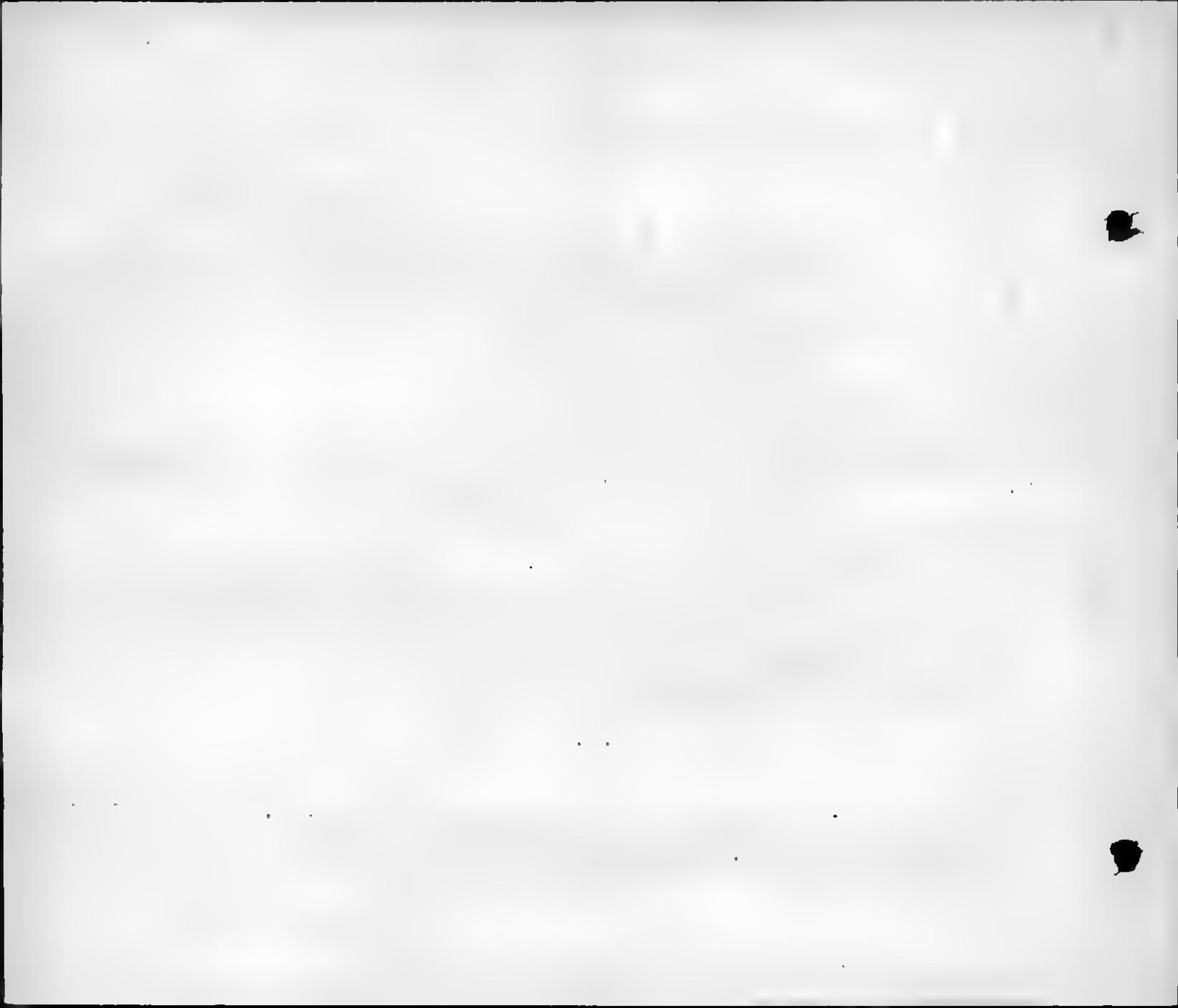
69610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 w/f</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Easton R.F.D.</i>		d. STREET ADDRESS <i>/</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.F.D.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Antonina</i>	Last <i>Sampson Jr</i>	4. DATE OF DEATH	Month <i>8</i>	Day <i>23</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/11/60</i>	9. AGE (In years lost birthday) — yrs. <i>5</i>	IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>— —</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John A. Sampson sr</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Monroe</i>		Address <i>Ruth Sampson, Easton, md</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>— —</i>		17. INFORMANT <i>INTERSTITIAL PNEUMONIA</i>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>INTERSTITIAL PNEUMONIA</i>		DUE TO <i>—</i>		DUE TO <i>—</i>		DUE TO <i>—</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		(b) <i>—</i>		(c) <i>—</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>P.M.</i> , 19 <i>—</i> , to <i>—</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>—</i> , 19 <i>—</i> , and that death occurred at <i>—</i> , 19 <i>—</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Louis S. Welty</i>		ADDRESS (Street, city or town, state) <i>EASTON, MD.</i> DATE SIGNED <i>8-25-60</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/25/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Melvin's town cem</i>		22d. LOCATION (City, town, or county) <i>Easton, R.F.D. Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jame... S. Welty, Easton, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>DATING 30 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Louis S. Welty</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

UNINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09611

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 12 hr. 25 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elfriede	First F.	Middle S.	Last Schneider
4. DATE OF DEATH Aug 24 1960	Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 1-31-1891	9. AGE (in years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) France
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Joseph Schneider Denton, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction		24 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Atherosclerotic coronary dis-		?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) Diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) Denton (County) Md. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 8/23/60 to 8/24/60 , that (I) (we) last saw the deceased alive on 8/27/1960 and that death occurred 8/24/60 M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE M. E. Cox		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) P. Evans Cox		22d. ADDRESS Earle Ave. Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-27-60	23c. NAME OF CEMETERY OR CREMATORIAL Henton	23d. LOCATED ON (City, town, or county) Henton Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boelaeis Greensboro, Md.		ADDRESS	25a. REC'D BY REGISTRAR AUG 29 '60
			25b. REGISTRAR'S SIGNATURE C. E. Cox

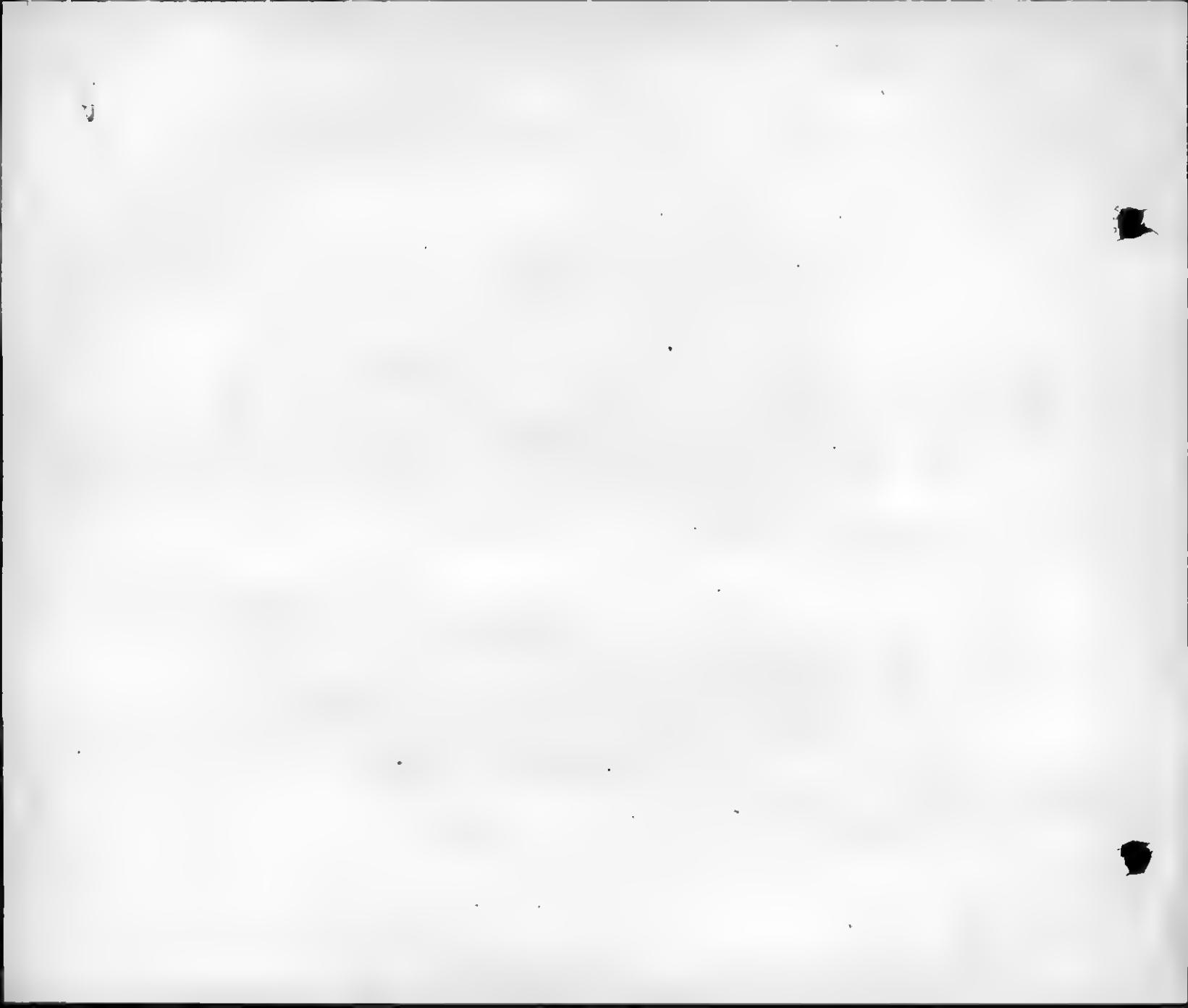


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9631

09612

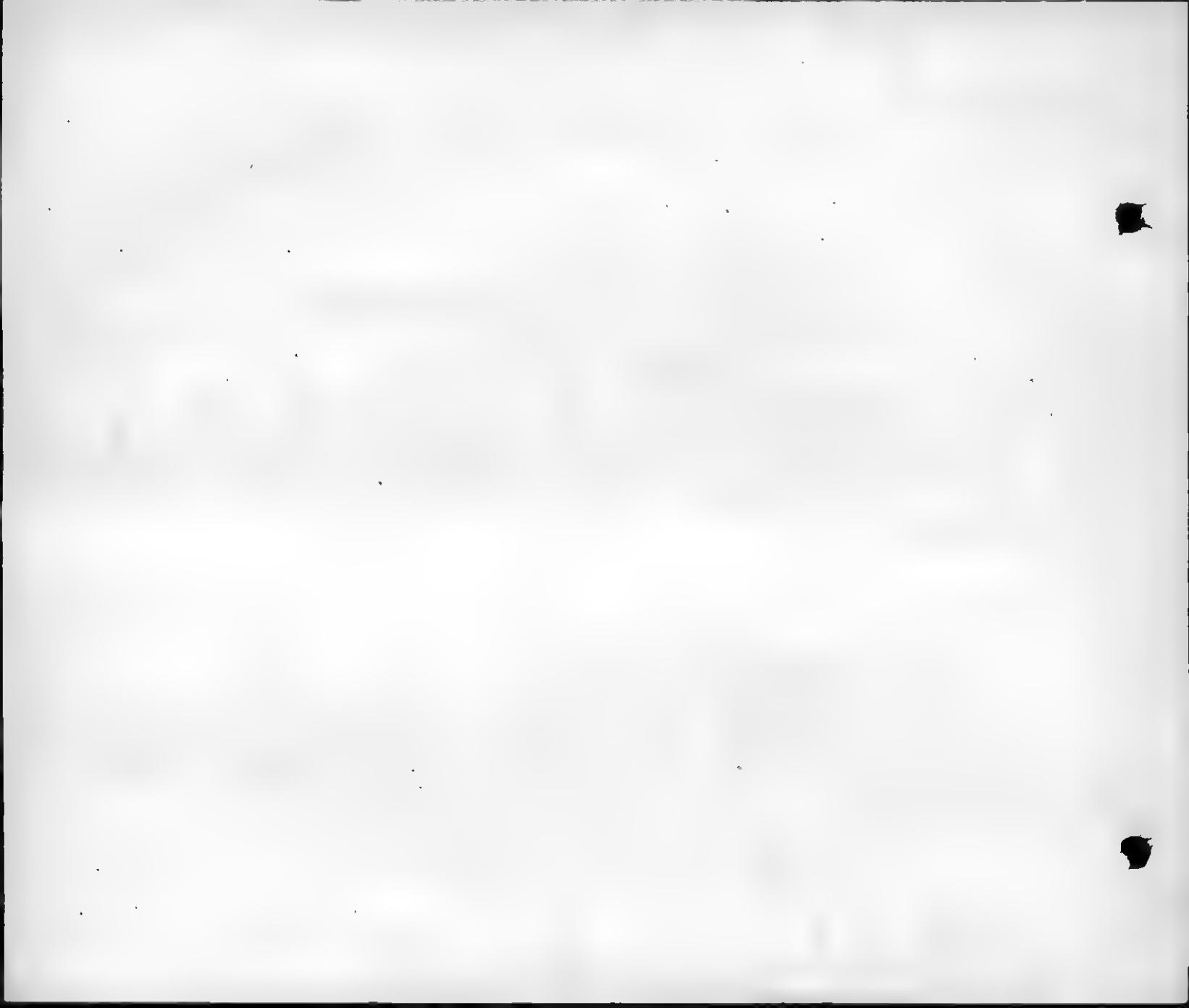
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN lb <i>25 min.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X WITTMAN</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Emil J. Dorell Schomborg</i>		4. DATE OF DEATH <i>August 17 1960</i>	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>AUG. 26, 1915</i>	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years <i>44 yrs.</i>) (At birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POSTMASTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>EMIL R. SCHOMBORG</i>		14. MOTHER'S MAIDEN NAME <i>KATHERINE DORRELL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>214-01-4368</i>	
17. INFORMANT <i>Mrs. E. DORRELL SCHOMBORG, WITTMAN, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial dysfunction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hr.</i>	
DUE TO <i>4351</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <i>atherosclerotic occlusive coronary artery d-</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-15</i> to <i>8-17</i> , 19 <i>60</i> , that (I) (he) last saw the deceased alive on <i>8-17</i> , 19 <i>60</i> , and that death occurred <i>8-17</i> A.M., from the causes and on the date stated above.		22b. DATE SIGNED <i>8-17-60</i>	
22a. SIGNATURE <i>Dr. John J. Healy</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS	
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>Aug. 19, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>TILGHMAN CEMETERY</i>		23d. LOCATION (City, town, or county) <i>TILGHMAN, MD.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Healy, Jr. Nichols</i>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE <i>AUG 19 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9632		19613											
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Queenstown</i> d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>LeCompte</i>	Last <i>Sensey</i>	4. DATE OF DEATH Month <i>August</i> Day <i>20</i> Year <i>1960</i>								
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JUNE 25 1907</i>		9. AGE (In years last birthday) <i>53 yrs.</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Merchant</i>		11. BIRTHPLACE (State or foreign country) <i>Queen Anne's Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Samuel W Sensey</i>					14. MOTHER'S MAIDEN NAME <i>Fannie Kinable</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>179-07-0059</i>		17. INFORMANT <i>Mrs Alice W Sensey Queenstown Md</i>		Address <i></i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>120-1</i>					<i>Coronary artery disease</i> <i>disease -</i> <i>myocardial infarction</i> <i>Cardiac failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>(?)</i> <i>3 days</i> <i>2 wks</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					DUE TO <i>due to</i> <i>due to</i> <i>due to</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury occurred</i>								
20c. TIME OF INJURY Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Calvert County</i>		(County) <i></i>		(State) <i></i>		
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1957</i> to <i>20 Aug 1960</i> that (I) (we) last saw the deceased alive on <i>20 Aug 1960</i> , and that death occurred at 9 P.M. from the causes and on the date stated above													
22a. SIGNATURE <i>Thurston Harrison</i>					M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i></i>					
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>					22d. ADDRESS <i>Calvert County</i> <i>Aug 20 1960</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 23-60</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Church Hill</i>			23d. LOCATION (City, town, or county) <i>Church Hill</i>		(State) <i>Maryland</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Lewis & Son Funeral Home</i>					ADDRESS <i>111 Calvert Street</i>		25a. REC'D BY REGISTRAR <i>AUG 25 1960</i>		25b. REGISTRAR'S SIGNATURE <i>W. E. Lewis</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

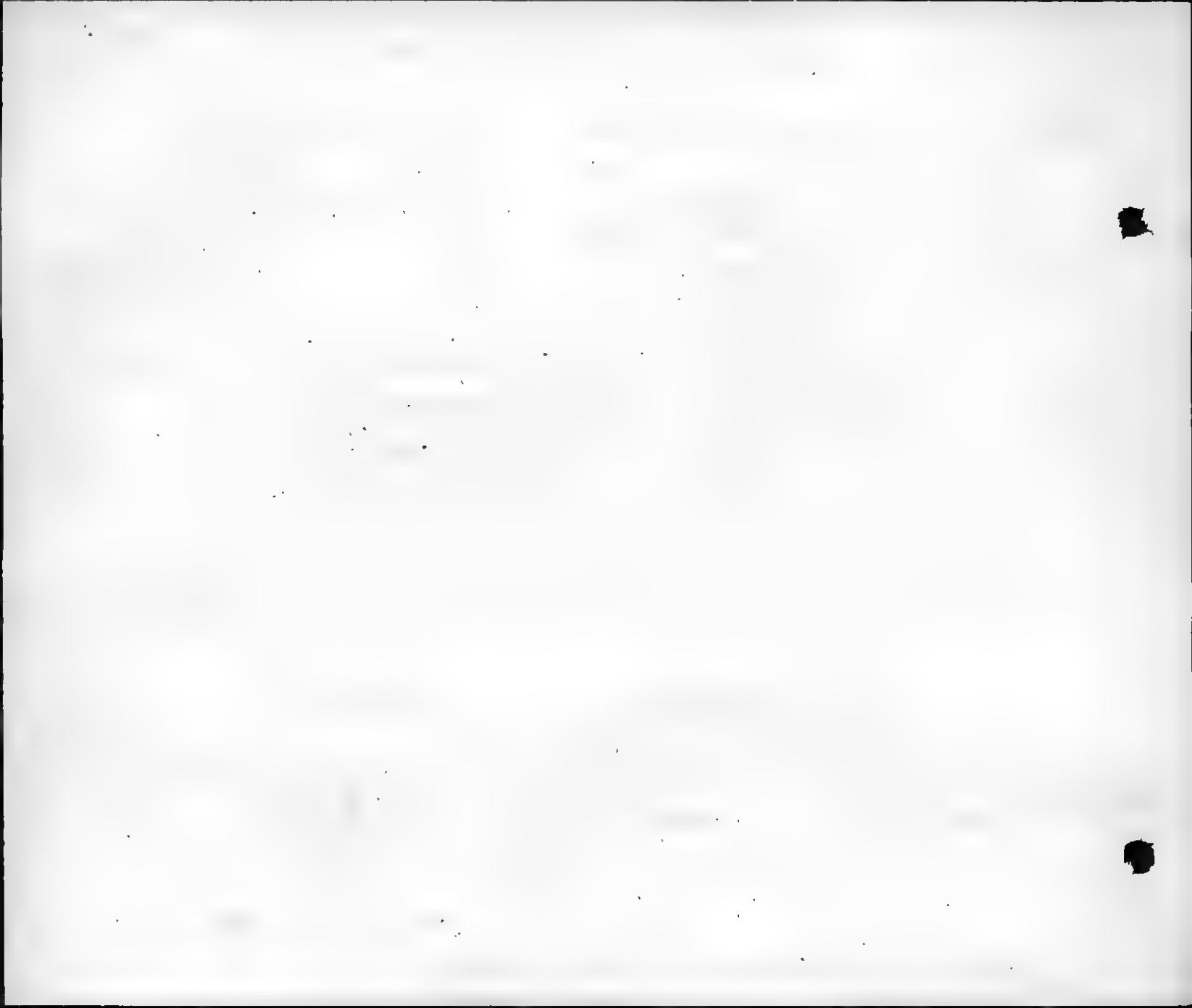
09614

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9633		CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 9 mos.									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 224 Wye Avenue									
3. NAME OF DECEASED (Type or print) Hilda K.		First		Middle		Last		4. DATE OF DEATH August 9		Month Day Year 1960	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/9/1895		9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Joseph J. Klein		14. MOTHER'S MAIDEN NAME Sarah Balser									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT Morton L. Shearer - Same		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 152		Acute Gastro-enteritis with large hemorrhage 24 hrs.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Cereumia of the colon 3 yrs.									
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July 1953, to Aug 1960 that I last saw the deceased alive on Aug 1960, and that death occurred at 3:45 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE THURSTON HARRISON		ADDRESS (Street, city or town, state) Eddy, Keyland									
PHYSICIAN'S NAME (Type)		DATE SIGNED Aug 60									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8/11/60		22b. DATE THEREOF Hebrew Cemetery		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town or county) Baltimore Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Sol Leinwand & Sons Inc.		ADDRESS 6010 First St #15		24a. REC'D BY REGISTRAR AUG 12 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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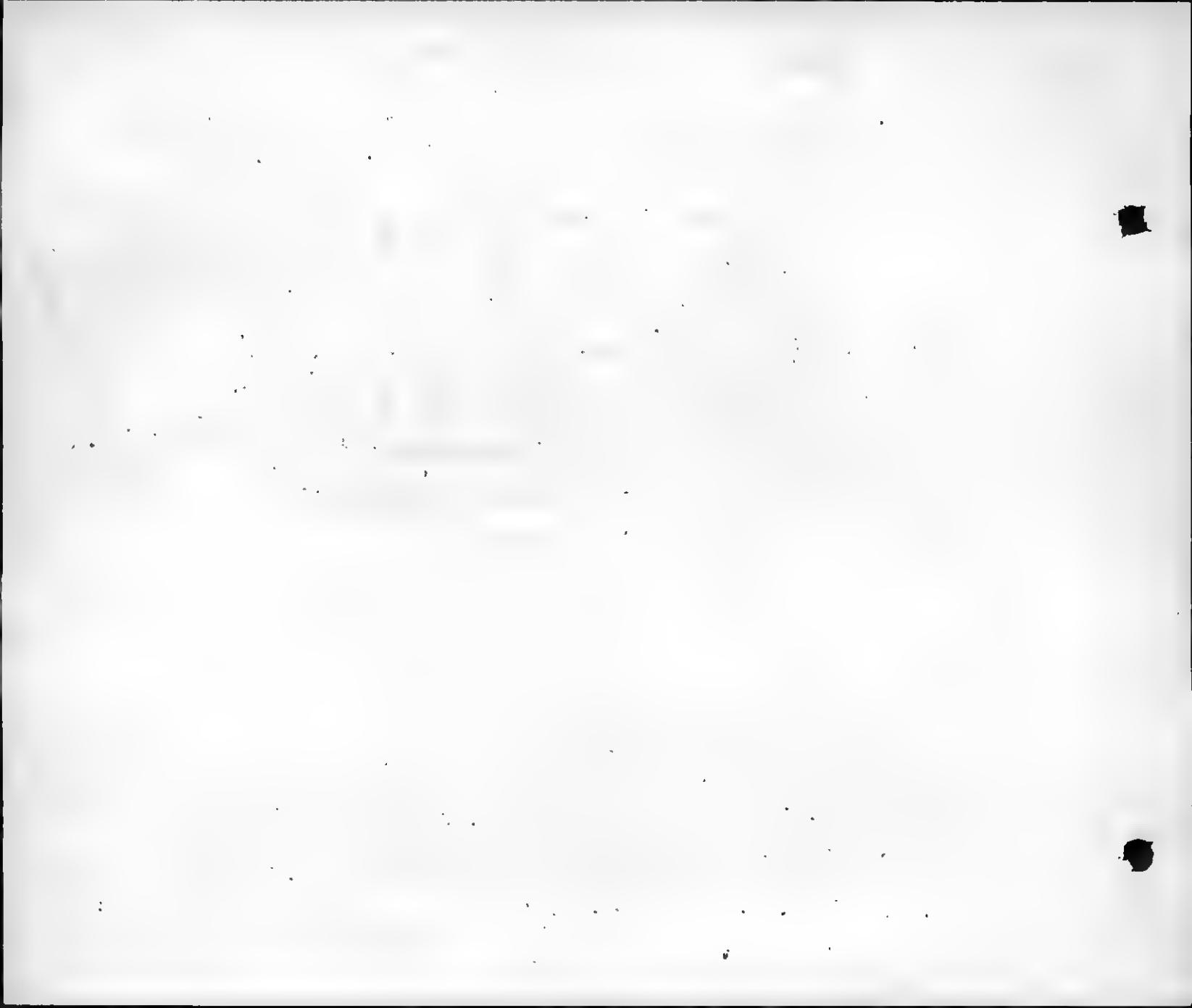
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
TALBOT MARYLAND		a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
EASTON	7 days	DENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 05X2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Florence	Middle Smith	Last
4. DATE OF DEATH	Month Aug	Day 2	Year 1960
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1885
9. AGE (In years lost birthday) 75 yrs.	10. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME Annie Sampson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT Freddie Dorange 718 Mary St Chester, Pa	
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX DUE TO <i>Cerebral Vasculitis Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 31, 1961, to August 7, 1961, that I last saw the deceased alive on August 1, 1961, and that death occurred at 5 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Gottlieb C. Friesinger, M.D.</i>	202 Done Street Easton, Maryland		
PHYSICIAN'S NAME (Type) Gottlieb C. Friesinger			
22a. FUNERAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 5, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Spring Grove	22d. LOCATION (City, town, or county) Denton, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Mooreson</i>	ADDRESS Denton	24a. REC'D BY REGISTRAR DATE AUG 15 '60	24b. REGISTRAR'S SIGNATURE <i>Albert S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

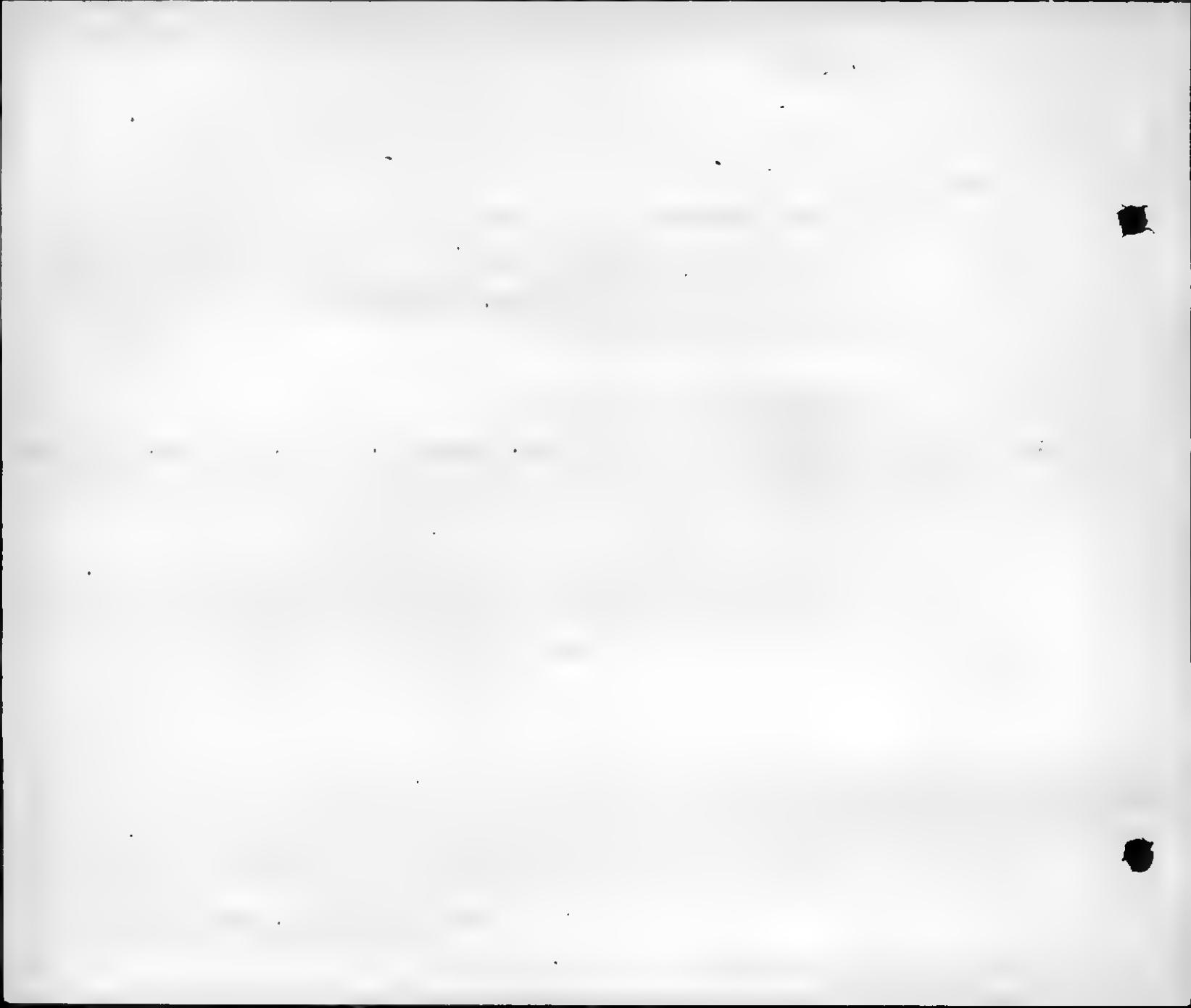
may be signed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

19616

1. PLACE OF DEATH o COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c LENGTH OF STAY IN 1b <i>35 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston</i>		d. STREET ADDRESS <i>none</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Thomas</i>	Middle <i>Hubert</i>	Last <i>Suitt</i>	4. DATE OF DEATH	Month <i>August</i>	Day <i>23</i>	Year <i>1960</i>
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 22, 1914</i>	9. AGE (In years last birthday) <i>46 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Hubert Suitt</i>				14. MOTHER'S MAIDEN NAME <i>Mannie Cash</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>111-11-1111</i>			
17. INFORMANT <i>Mrs. Louise H. Suitt, Preston, Maryland</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>40</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) and the direct cause (c) <i>hypertrophic myocardial infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
DUE TO <i>hypertrophic myocardial infarction</i>							
DUE TO <i>Coronary thrombosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21 I certify that (I) (this hospital) attended the deceased from <i>23 Aug 1960</i> to <i>23 Aug 1960</i> , that (I) (we) last saw the deceased alive on <i>23 Aug 1960</i> and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Thurston Harrison</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>23 Aug 60</i>			
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>				22d. ADDRESS <i>Carke, Maryland</i>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/26/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Spring Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Easton, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. Thompson Carroll Easton, Md</i>				25a. REC'D BY REGISTRAR <i>Arthur S. Kirsch</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kirsch</i>	
				DATE AUG 29 '60			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9636

CERTIFICATE OF DEATH

09617

Reg. Dist. No.

M

1. PLACE OF DEATH

a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY IN 1b

5 3/4 hrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

The Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Caroline

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Denton

d. STREET ADDRESS

?

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
8

Day
6
Year
1960

5. SEX

F

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

8/16/60

9. AGE (In years
lost birthday)
yrs.

IF UNDER 1 YEAR
Months
6
Hours
45
Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Rufus Webb

14. MOTHER'S MAIDEN NAME

Ketty Jane Purcell

S. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

Address

Rufus Webb Denton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

76a.5
Due to
Conditions, if any which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b) *Prematurity*

Due to

Anoxemia

(c)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Doy, Year
Hour o. m. p. m. 19

20d. INJURY OCCURRED
White Not white
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from E. J. G., 1960, to E. J. G., 1960, that I last saw the deceased alive on E. J. G., 1960, and that death occurred at M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED
8/9/60

ACTUAL
SIGNATURE

E. D. Hardy

M.D.

Talbotton, Easton, Md.

PHYSICIAN'S
NAME (Type)

ERVING D. HARDY M.D.

Same as above

22a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial Aug. 8, 1960

22c. NAME OF CEMETERY OR CREMATORIUM

St. Paul

22d. LOCATION (City, town, or county)

Wilmington Delaware

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

G. V. Moore & Son Denton, Md.

ADDRESS

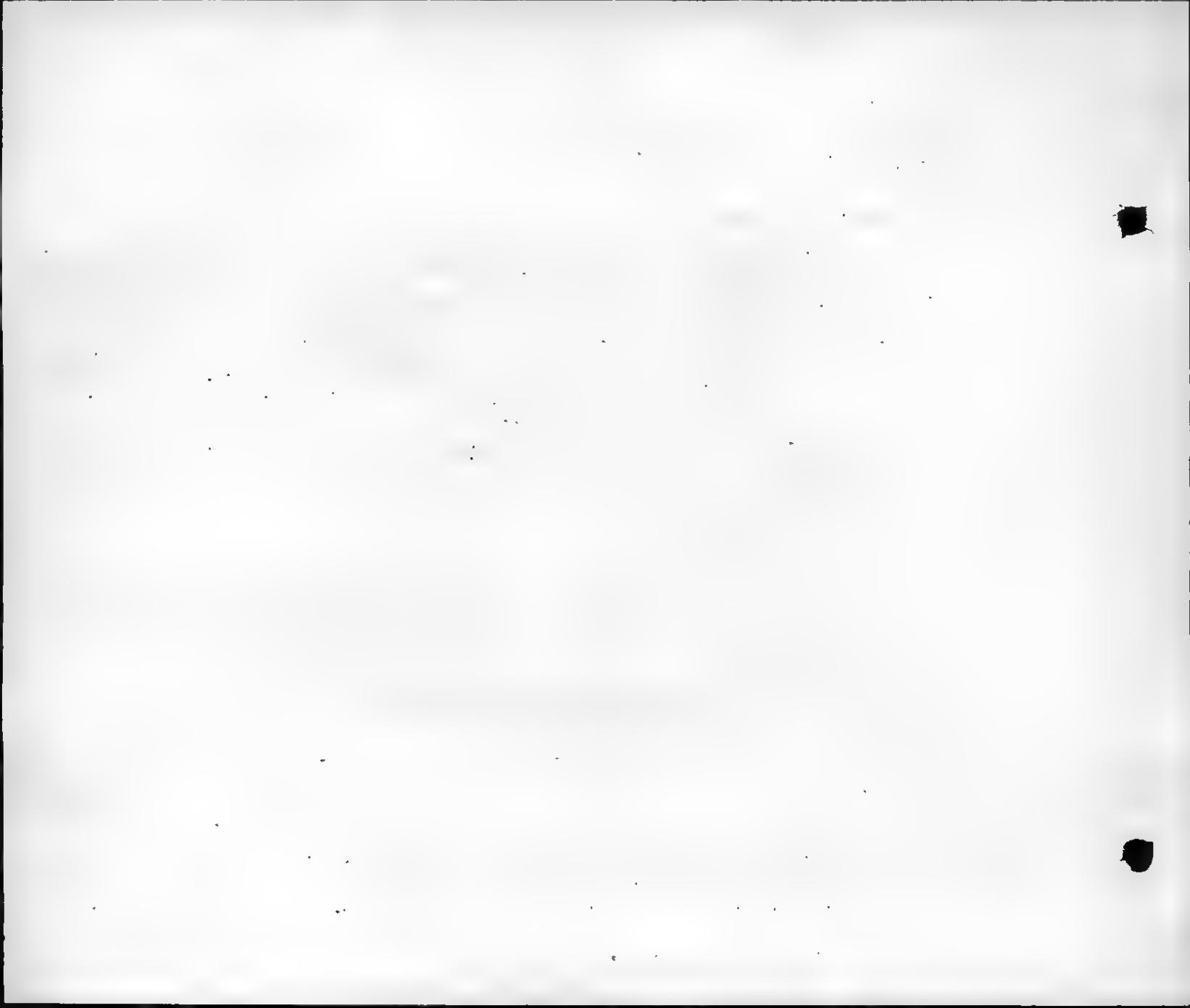
24a. REC'D BY REGISTRAR

AUG 15 '60

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Thorne



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

69618

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b The 30th	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Bradley Whiteley		First	Middle
4. DATE OF DEATH August 11 1960		Month	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1906
9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Vienna, Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Weeb Bradley		14. MOTHER'S MAIDEN NAME Ethel Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-5068	
17. INFORMANT Walter C. Whiteley, Williamsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
+43 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)		(?)	
DUE TO Cardiac failure			
(c) DUE TO Hypertension C-V disease			
DUE TO Cosential hypertension		2 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 Aug 1960 to 11 Aug 1960 , that (I) (we) last saw the deceased alive on 11 Aug 1960 , and that death occurred at 6:20 P.M. from the causes and on the date stated above		22b. DATE SIGNED 11 Aug 60	
22a. SIGNATURE Hurston Harrison		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (if not M.D.) HURSTON HARRISON		22d. ADDRESS Carson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 14, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Washington Cemetery		23d. LOCATION (City, town, or county) (State) Hurlock, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Frampton & Son		ADDRESS Federalburg, Maryland	25a. REC'D BY REGISTRAR DATE AUG 16 '60
		25b. REGISTRAR'S SIGNATURE Charles L. Times	



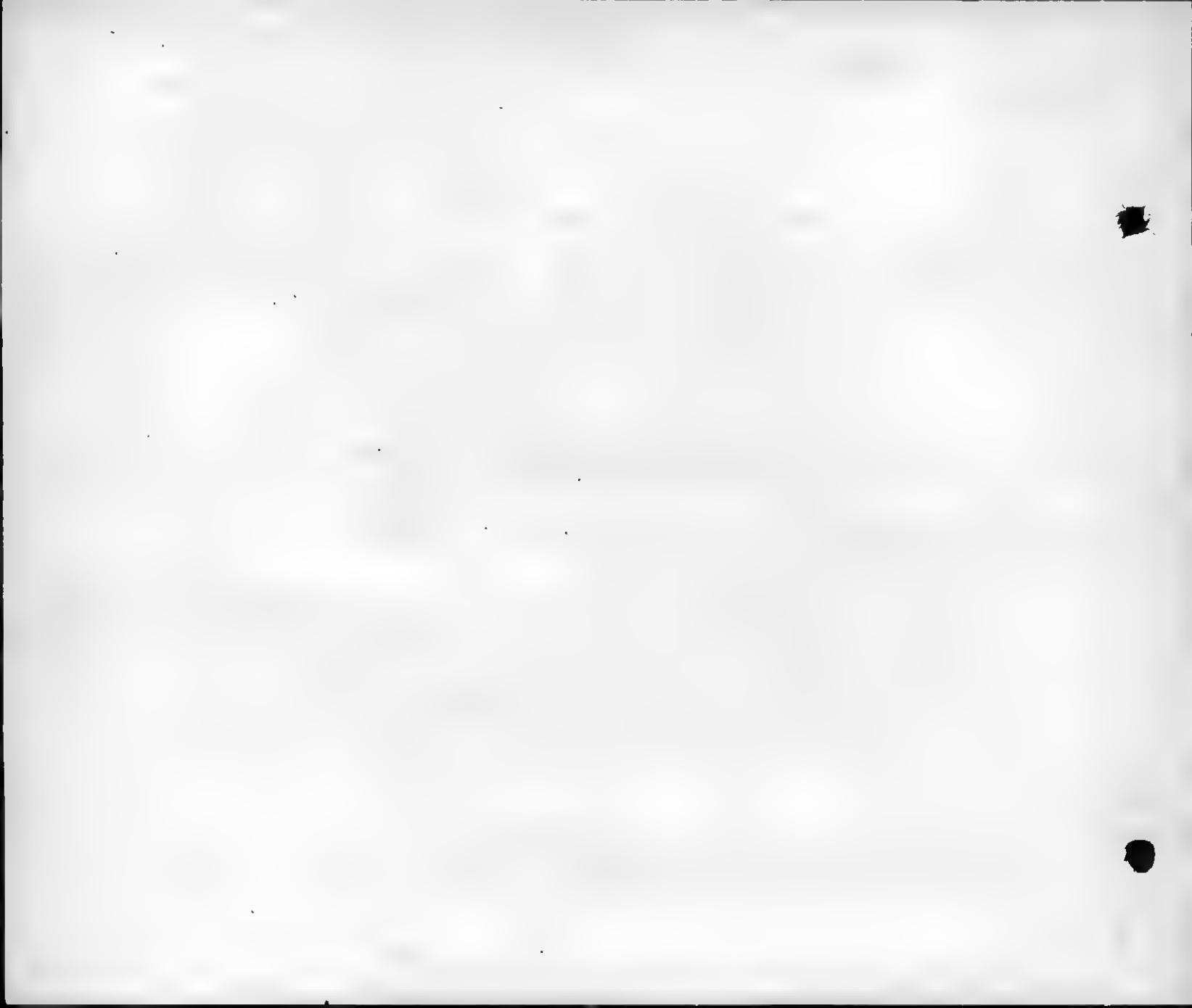
TO HOSPITAL [Redacted] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

199619

1. PLACE OF DEATH a. COUNTY		Item 1 (item 1) (a) (b) (c) (d) et al		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Tolbot		MARYLAND		Florida	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Caston		7 days		Duval	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Memorial Hospital				4 E.	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Daisy				August 27	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female		130		1414	46 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Factory		Florida	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				Hosp. Records	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)					
23 Cerebral hemorrhage					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
Cerebral hemorrhage					
DUE TO (c)					
Cerebral hemorrhage					
INTERVAL BETWEEN ONSET AND DEATH 9 (?)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 Aug 1960 to 27 Aug 1960, that (I) (we) last saw the deceased alive on 26 Aug 1960, and that death occurred at 4 P.M. from the causes and on the date stated above.					
22a. SIGNATURE		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
DR Thurston Harrison				22b. DATE SIGNED 28 Aug 60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Caston Bay Land			
DR Thurston Harrison		DR Thurston Harrison			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		9/3/60		Int. Olive Park Jacksonville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
James B. Darrell Eastman		ADDRESS		25b. REGISTRAR'S SIGNATURE DATE SEP 7 '60	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

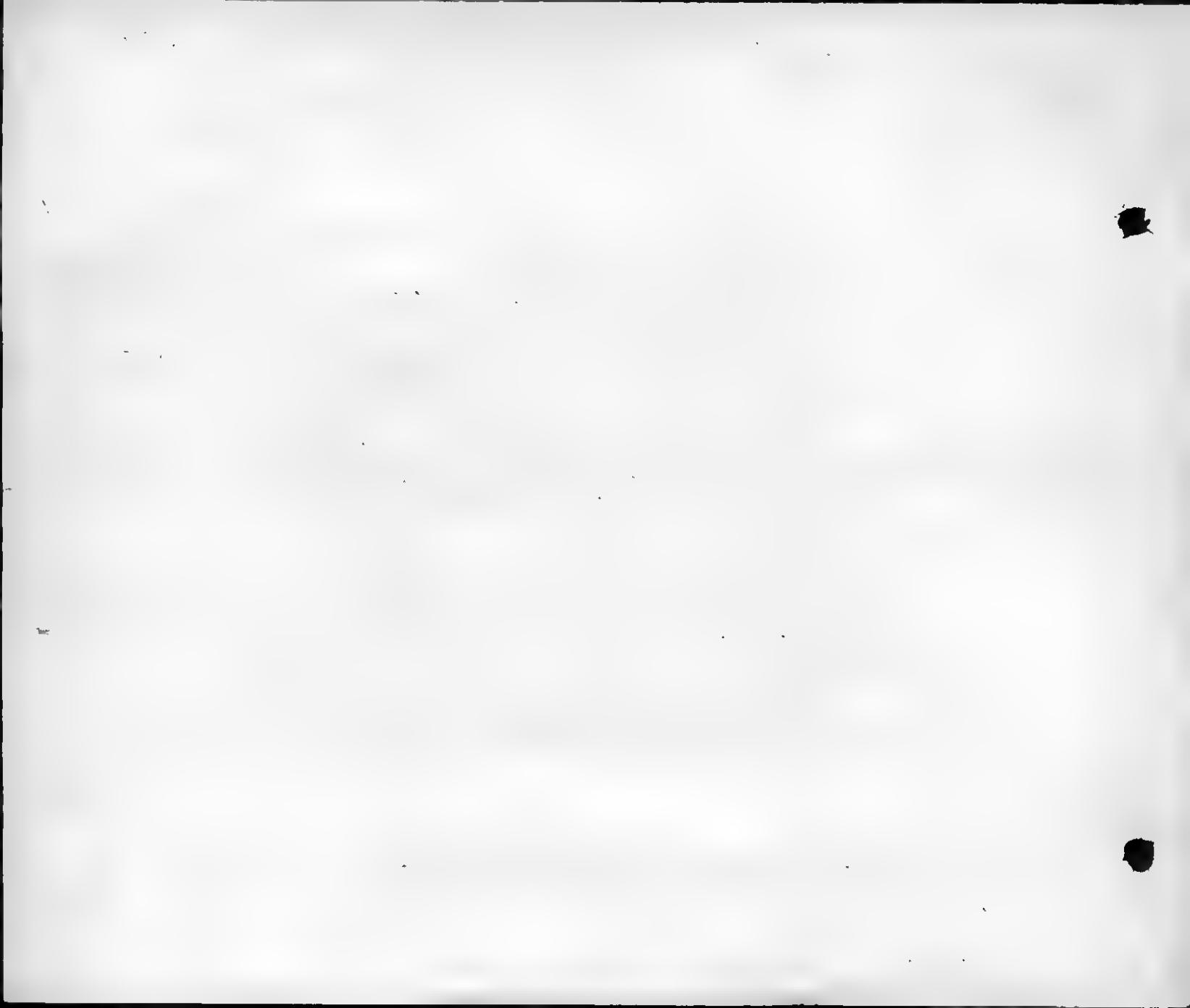
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

19620

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>13 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		d. STREET ADDRESS <i>187D</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Ethel</i>	Middle	Last <i>Williams</i>	4. DATE OF DEATH <i>August 17 1960</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/20/90</i>	9. AGE (In years last birthday) <i>70 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>	Address <i>Raymond Williams, Easton, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>—</i>							
16. SOCIAL SECURITY NO. <i>—</i>							
17. INFORMANT <i>Chase Lymphatic Leukemia</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>2040</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20F (City or town)</i>		(County) (State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 19 57</i> to <i>8/17 1960</i> , that (I) (we) last saw the deceased alive on <i>8/17 1960</i> , and that death occurred at <i>610P</i> , from the causes and on the date stated above							
22a. SIGNATURE <i>J. Eglseider</i>				22b. DATE SIGNED <i>8/17/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>J. EGLSEIDER</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>8/24/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Wellington Cemetery</i>	23d. LOCATION (City, town or county) <i>Easton R. 2, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Darrell</i>				ADDRESS <i>Easton, Md.</i>	25a. REC'D BY REGISTRAR <i>AUG 29 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
VR A15 (4) 1SM 9/5M							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

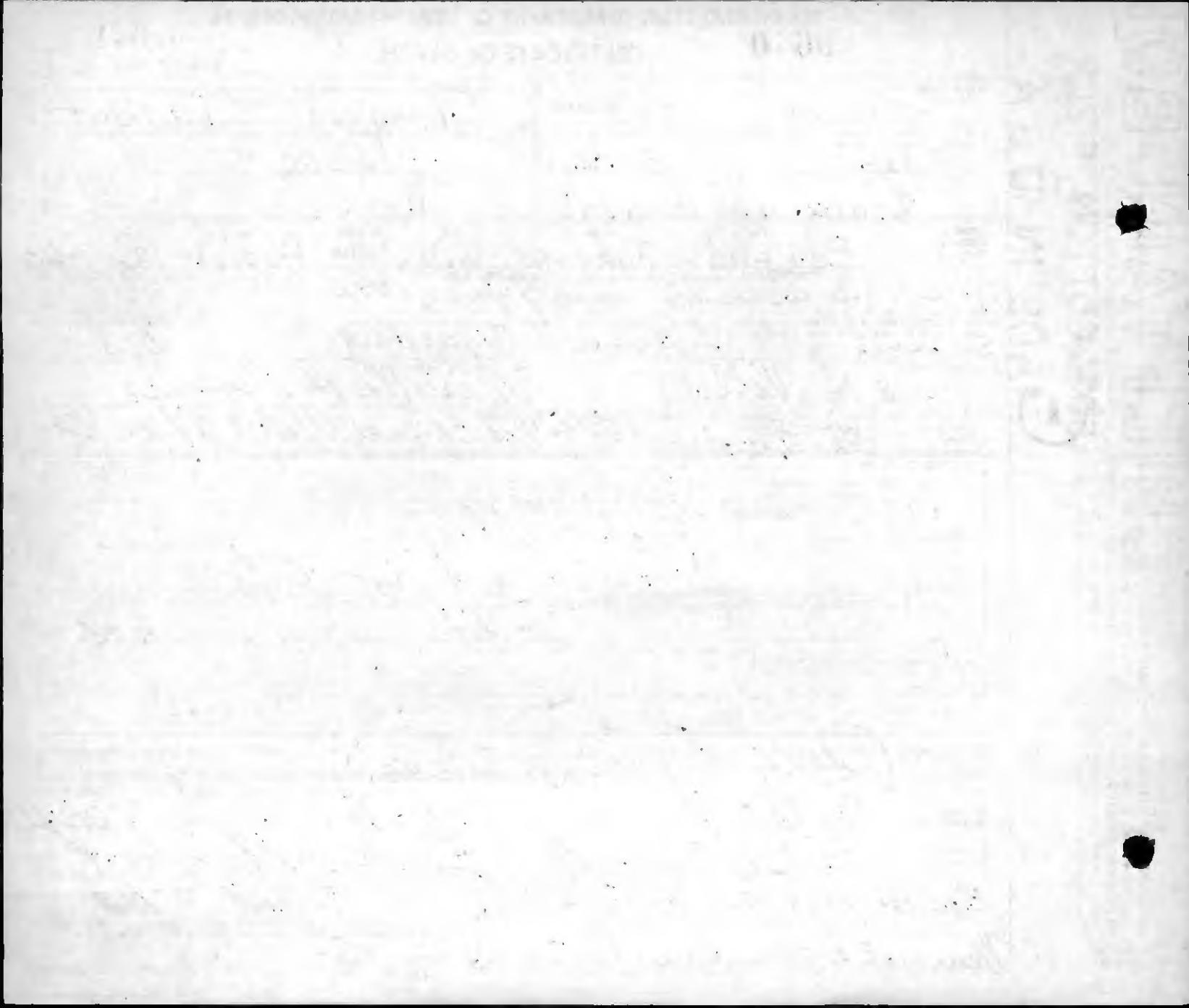
9640

CERTIFICATE OF DEATH

119641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Talbot		a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 51 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxford	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Edward	Middle HARRISON
		Last Willis	4. DATE OF DEATH August 2 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. BIRTH DATE July 29, 1892		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture	10c. BIRTH PLACE (State or foreign country) Maryland
10d. COUNTRY OF BIRTH U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Willis		14. MOTHER'S MAREN NAME Marcella H. Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. 75-17-1212-20-20	INFORMANT Mrs. Edward Willis Alfred Met.
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		Chronic	
(c) DUE TO		Pyphromyphosis Carcinoma of prostate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		M.D. 2195 West Virginia St. Apt. 10 Elkridge	
PHYSICIAN'S NAME (Type)		E.C.H. Schmidt	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug 4, 1960	22c. NAME OF CEMETERY OR CREMATORIAL OXFORD CEM.
22d. LOCATION (City, town or county)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
Maurice E. Neumann & Son		Easton, Md.	24b. REGISTRAR'S SIGNATURE
VS A15 (4) 15M 9/58		DATE AUG 8 '60	RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FOR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G269 8-19-60 et

CERTIFICATE OF DEATH

119622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Talbot</i>		MARYLAND <i>Maryland</i> Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
RURAL <i>EASTON</i>		6da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Memorial Hospital</i>		<i>Ridgely</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>FRANK</i>	Middle <i>Juma</i>
4. DATE OF DEATH		Month <i>Aug</i>	Day <i>10</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	B. DATE OF BIRTH
8. AGE (In years at birthday)		9. UNDER 1 YEAR	IF UNDER 24 HRS.
78 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Farm Labourer</i>		<i>Farming</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Poland</i>		Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>unknown</i>		<i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
no		<i>Syr. Wm. Dedford, Jr., Ridgely, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i>			
DUE TO <i>2 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>a-H-D</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/4/60</i> , 19, to <i>8/10/60</i> , 19, that I last saw the deceased alive on <i>8/10/60</i> , 19, and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>EASTON, MD</i> DATE SIGNED <i>8/10/60</i>	
ACTUAL SIGNATURE <i>P F Cox</i>		M.D. <i>EASTON, MD</i>	
PHYSICIAN'S NAME (Type) <i>P F Cox</i>		EASTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 12, 1960</i>		22b. DATE THEREOF <i>Aug 12, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Haley Cross</i>		22d. LOCATION (City, town, or county) (State) <i>Denton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mount Zion Denton, Md.</i>		ADDRESS <i>Mount Zion Denton, Md.</i>	
24a. REC'D BY REGISTRAR <i>AUG 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	
DATE <i>AUG 15 '60</i>			

